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MEDICARE AND MEDICAID HEALTH BUDGET RECONCILIATION AMENDMENTS OF 1989

A REPORT

PREPARED BY THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON ENERGY AND COMMERCE

U.S. HOUSE OF REPRESENTATIVES

TOGETHER WITH

DISSENTING VIEWS

AUGUST 1989

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LETTER OF TRANSMITTAL

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC, August 4, 1989.

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce, Washington, DC.

DEAR MR. CHAIRMAN: On July 13, 1989, the Committee on Energy and Commerce considered a committee print making changes in the Medicare and Medicaid programs consistent with the Concurrent Budget Resolution for fiscal year 1990, H. Con. Res. 106. The committee ordered the print, as amended, transmitted to the Committee on the Budget for inclusion in that committee's omnibus budget reconciliation bill. The text of the print, as amended, was introduced as H.R. 2924.

The subcommittee has received numerous requests for copies of the committee and dissenting views regarding H.R. 2924. This document sets forth those committee and dissenting views, but not the statutory text of H.R. 2924 itself. I believe that the availability of these views will be useful to both the members and the public.

I would note that, as of this writing, the provisions reported by the committee, reflected in H.R. 2924, as well as the committee and dissenting views, have not been formally transmitted to the Committee on the Budget. Those provisions, as well as the enclosed committee and dissenting views, remain subject to change by the Committee on Energy and Commerce until formal transmittal.

With all best wishes, I am

Sincerely,

HENRY A. WAXMAN,
Chairman, Subcommittee on Health and the Environment.

CONTENTS

MEDICARE AND MEDICAID HEALTH BUDGET RECONCILIATION AMENDMENTS OF 1989

PURPOSE AND SUMMARY

The purpose of the Medicare and Medicaid Health Budget Reconciliation Amendments of 1989 is to make revisions in Part B of the Medicare program and in the Medicaid program, in accordance with the budget instructions contained in the Concurrent Resolution on the Budget—fiscal year 1989 (H. Con. Res. 106)

The committee bill consists of five subtitles. Subtitle A, containing Medicare Part B provisions, consists of three parts. Part A of subtitle A contains changes in payments for physician services under Medicare, changes in payments for other services covered under Medicare, and changes in the benefits and coverage rules for a variety of services. The most prominent provision in subtitle A, Part A is the comprehensive reform in the method of paying for physician services. The bill would replace the current "reasonable charge" method with a fee schedule, using a resource-based relative value scale. Most of the savings in the bill, in response to the instructions of the budget resolution, are achieved through the elimination of the annual update for physician fees. This part also provides new coverage for pap smears, expands mental health services, refines several provisions from recent reconciliation acts, and requires several studies designed to help resolve policy issues in the future. It would also provide protection against out-of-pocket expenses for Medicare enrollees who have their cost-sharing paid under Medicaid.

Part B of subtitle A of the bill includes changes designed to improve the performance of health maintenance organizations and peer review organizations, an enhancement in payments for primary care residency programs, and a provision making information on preventive health practices available to Medicare enrollees.

Part C of subtitle A contains miscellaneous provisions relating to health programs within the jurisdiction of the committee. It would instruct the Secretary of Health and Human Services to appoint administrative law judges who would hear health-related cases exclusively. It would make technical changes in the Bipartisan Commission on Comprehensive Health Care and would elevate the current Office of Rural Health Policy to the office of the undersecretary. It also includes a resolution expressing the sense of the House of Representatives that the committee, and the Committee on Ways and Means, review the Medicare Catastrophic Coverage Act and hold hearings, and another resolution expressing the sense of

the Congress that the Medicare benefits and premiums enacted last year in the catastrophic act be made voluntary during this session.

Subtitle B establishes the Agency for Health Care Research and Policy, and consists of four parts. Part A amends the Public Health Service Act to establish a new Agency for Health Care Research and Policy and, within the Agency, a Forum for Quality and Effectiveness in Health Care. Part B amends the Social Security Act to provide for a program of research on the outcomes of medical care, to be conducted through the Agency. Parts C and D contain general and transitional provisions needed to implement Parts A and B.

Subtitle C, containing Medicaid provisions, consists of five parts. Part A consists of infant mortality provisions to expand Medicaid coverage for pregnant women and infants and provide appropriate services for this population. Part B, the "Child Health Amendments," phases in mandatory coverage of children up to 100 percent of the poverty level. Part C, the "Community and Facility Habilitation Services Amendments," extends, on a State option basis, the availability of community services to individuals with mental retardation or a related condition, establishes quality assurance guidelines for services in the community and institutions, and outlines protections for employees of institutions where services to this population are provided. Part D, the "Frail Elderly Community Care Amendments," establishes community care for the frail elderly as a optional, statewide service, and Part E mandates hospice care as a covered service under the Medicaid program. Part F contains miscellaneous amendments to the Medicaid program, including provisions relating to nurse aide training, preadmission screening, and other matters relating to nursing home reform contained in the Omnibus Budget Reconciliation Act of 1987.

Subtitle D is a reauthorization of the Maternal and Child Health Block Grant Program. It contains an increase in the authorization level and improvements in the program's structure and operation.

Subtitle E, "Miscellaneous Health-Related Provisions," includes technical amendments to the National Childhood Injury Vaccine Compensation program. It also includes a technical amendment on Congressional access to information from the Food and Drug Administration and mandates a study by the Comptroller General on health benefits for retirees of a bankrupt employer.

BACKGROUND AND NEED FOR THE LEGISLATION

The Concurrent Resolution on the Budget—fiscal year 1990 (H.Con.Res. 106, adopted May 17, 1989) provided for unspecified savings in the Medicare program of $2.3 billion in fiscal years 1990 and 1991. The Budget Resolution assigns this savings target to both this committee and the Committee on Ways and Means, without instructions as to how much is to be achieved in Part A, which is not within the jurisdiction of this committee, and how much is to be achieved in Part B, which is within the jurisdiction of both committees. Therefore, this committee does not have a specific target for the Medicare savings it must achieve. The net savings from this committee are consolidated with the net savings from the Committee on Ways and Means to determine whether the target has been met. This year, as in the past, the committee has attempted to

achieve its savings without reducing benefits or increasing the out-of-pocket expenses of the Medicare enrollees. The committee is also concerned, however, that continual reductions in payments to providers of service, without adequate evaluation of the effects of prior reductions, will inevitably impact on enrollees in the form of reduced quality of care or barriers to accessibility.

The Budget Resolution also provides $200 million in new entitlement authority for fiscal year 1990 to begin Medicaid initiatives to combat infant mortality, improve child health, make community-based services available to the frail elderly and individuals with mental retardation, and require coverage of hospice services. The committee bill contains each of these initiatives. Under the bill, an additional 84,000 poor pregnant women and 64,000 poor infants would receive Medicaid coverage for prenatal care in fiscal year 1991. An additional 355,000 poor children between the ages of 1 and 7 would receive the preventive health care services under Medicaid that same year. About 15,000 individuals with mental retardation or a related condition would receive services in the community rather than an institution. And community-based services would reach approximately 15,000 low-income frail elderly to help them avoid placement in a nursing home. In the view of the committee, these modest, incremental improvements respond effectively to the most urgent unmet needs of the three populations the Medicaid program serves: poor women and children, poor elderly, and poor disabled individuals.

HEARINGS

The Committee's Subcommittee on Health and the Environment held one day of hearings on Medicaid and the Mentally Retarded on September 30, 1989, and heard testimony from 19 witnesses, including three Members of Congress and the Congressional Budget Office. On February 8th, 1989, the subcommittee held hearings on the Medicaid Infant Mortality Initiatives. Testimony was received from 7 witnesses, representing the chairman of the National Commission to Prevent Infant Mortality, a Member of Congress and 5 other organizations. The subcommittee also held a one day hearing on March 13th, 1989 on the development and use of medical practice guidelines in assuring quality of health care. Testimony was received from 7 witnesses, representing the Physician Payment Review Commission, a health insurance association, and 5 medical associations. On May 25th, 1989, the subcommittee held a one day hearing on Medicare Physician Payment Reform. Testimony was received from 12 witnesses, including 2 Members of the House of Representatives, Chairman of the Physician Payment Review Commission, and 9 other organizations. The subcommittee held a one day hearing on June 8th, 1989 on Miscellaneous Medicare and Medicaid Reconciliation Provisions. Testimony was received from 24 witnesses, including a Member of Congress, the Congressional Budget Office, the Health Care Finance Administration, and 9 other organizations. Finally, on June 16, 1989, the subcommittee held a hearing on H.R. 2601, Health Care Research and Policy. Testimony was received from 7 witnesses, representing the Department of Health and Human Services, and 6 other organizations.

COMMITTEE CONSIDERATION

The Subcommittee on Health and the Environment met for 3 days, on June 22nd, 27th, and 28th, 1989, in closed session to discuss proposed Medicare and Medicaid reconciliation provisions. The subcommittee met in an open mark up session on June 29th, 1989, and ordered a Committee Print. On July 12th and 13th the committee met in an open mark up session and ordered the Committee Print with proposed amendments, transmitted to the Budget Committee by a recorded vote of 30 to 13, a quorum being present.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(1)(3)(A) of rule XI of the Rules of the House of Representatives, no oversight findings or recommendations have been made to the committee.

COMMITTEE ON GOVERNMENT OPERATIONS

Pursuant to clause 2(1)(3)(D) of rule XI of the Rules of the House Representatives, no oversight findings have been submitted to the committee by the Committee on Government Operations.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the committee believes that the bill will achieve budget savings in the Medicare program of $525 million in fiscal year 1990, and result in new Medicaid program outlays of $183 million in fiscal year 1990.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 1, 1989.

Hon. JOHN DINGELL,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for the provisions relating to spending in programs within the jurisdiction of the House Committee on the Budget by the House Committee on Energy and Commerce, July 13, 1989.

The estimates included in the attached report represent the 1990–1994 effects on the Federal budget and on the budget resolution baseline of the committee's legislative proposals. CBO understands that the staff of the Committee on the Budget will be responsible for interpreting how the savings contained in these legislative proposals measure against the budget resolution reconciliation instructions.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

ROBERT D. REISCHAUER, *Director.*

cc. Honorable Norman F. Lent, Ranking Minority Member.

HEALTH PROVISIONS OF 1990 RECONCILIATION BILL, ENERGY AND COMMERCE COMMITTEE

[Outlays in millions of dollars by fiscal year]

	1990	1991	1992	1993	1994
PART A—PROVISIONS RELATING TO PART B OF MEDICARE					
Subpart 1—Payment for Physicians' Services and Related Professional Services					
4001. Application of Resource-Based Relative Value Scale to Physicians' Services	0	0	0	0	0
4002. Freeze in Medicare Economic Index during 1990	−705	−700	−815	−920	−1,035
4003. Payment for Radiology Services	3	1	0	0	0
4004. Payment for Anesthesiology Services:					
a. Reduce Anesthesiologists	−45	−45	−55	−60	−65
b. Set CRNA Factors	70	185	205	230	255
c. No payment for Medical Direction	0	0	0	0	0
4005. Payment for Pathology Services	0	0	0	0	0
4006. Waiver of Liability	15	0	0	0	0
Subpart 2—Payment for Other Services					
4011. Durable medical equipment:					
a. Enteral and Parenteral Equipment	−6	−12	−15	−15	−20
b. Reduce Selected Fees	−12	−20	−25	−25	−30
4012. Clinical Diagnostic Laboratory Tests:					
a. Cap Payments at 95 percent of Median	−55	−85	−100	−115	−135
b. Eliminate "Shell" Labs	0	0	0	0	0
4013. Reduction in Capital Payments for Outpatient Hospital Services	−15	−45	−55	−65	−75
4014. Federally Qualified Health Centers	13	30	35	45	50
4015. Physical and Occupational Therapy Services	(1)	(1)	1	1	1
Subpart 3—Changes in Coverage and Miscellaneous					
4021. Mental Health Services:					
a. Direct Payment for Psych's, LCSW's	20	40	45	50	50
b. Eliminate $1,100 Limit	20	55	75	90	115
c. Interaction of a. and b.	2	9	13	16	19
4022. Nurse Practitioner Services—Direct Payment to NP's	10	15	15	20	20
4023. Coverage of Screening Pap Smears	65	135	155	165	175
4024. Rural Health Clinic Services	(1)	1	1	2	2
4025. Charge Limits for Medicare Bene's	(1)	(1)	(1)	(1)	(1)
PART B—PROVISIONS RELATING TO PARTS A AND B OF MEDICARE					
4041. Health Maintenance Organizations and Competitive Medical Plans	150	220	250	280	320
4042. Peer Review Organizations	0	0	0	0	0
4043. Payment for End Stage Renal Disease Services (eff. January 1, 1990)	−60	−110	−135	−165	−200
4044. Payments for Direct Medical Education	0	0	0	0	0
4045. Distribution of Information on Recommended Preventive Health Practice	5	6	7	8	9
PART C—PROVISIONS RELATING TO MEDICARE AND HEALTH RELATED PROGRAMS					
4061. Administrative Law Judges for Health-Related Cases	(1)	(1)	(1)	(1)	(1)
Total for Medicare Provisions	−525	−320	−398	−458	−544
Subtitle B—Health Care Research and Policy					
PART A—AGENCY FOR HEALTH CARE RESEARCH AND POLICY					
4101. Establishment of Agency	0	0	0	0	0
PART B—OUTCOMES OF HEALTH CARE SERVICES AND PROCEDURES					
4111. Establishment of Program of Research (Subject to Appropriation)	25	38	50	0	0

PART C—ADDITIONAL AUTHORITIES AND DUTIES WITH RESPECT TO AGENCY FOR HEALTH CARE RESEARCH AND POLICY					
4121. Advisory Council, Peer Review, Administrative Authorities, and Other General Provisions (Subject to Appropriations)	35	50	70	0	0
PART D—GENERAL PROVISIONS					
4131. Terminations	0	0	0	0	0
4133. Technical and Conforming Amendments to Public Health Service Act	0	0	0	0	0
4134. Transitional Provisions	0	0	0	0	0
Total for Health Care Research (Subject to Appropriations)	60	88	120	0	0
Subtitle C—Medicaid					
PART A—INFANT MORTALITY PROVISIONS					
4201. Medicaid Coverage of Pregnant Women and Infants:					
(a) Phased-in Coverage	60	140	165	320	500
(b) Flexibility in Income Methodology/Computation	1	2	3	3	4
(c) Prohibit Resource Test	7	30	35	40	40
(d) Errors in Eligibility	0	0	0	0	3
4202. Presumptive Eligibility and Outreach for Pregnant Women:					
(a) Extend Period	0	0	0	0	0
(b) Application Flexibility	(1)	(1)	(1)	(1)	(1)
4203. Optional Coverage of Prenatal and Postpartum Home Visitation Services	3	10	10	10	15
4204. Payment for Obstetricial and Pediatric Services:					
(a) Codification of Adequate Levels	0	0	0	0	0
(b) Assuring Adequate Levels	1	3	3	3	3
(c) Payment in Federally-Funded Health Centers	9	10	10	15	15
4206. Role in Paternity Determination	(1)	(1)	(1)	(1)	(1)
4207. Required Medicaid Notice and Coordination with Special Supplemental Food Program for Women, Infants, and Children	1	2	2	2	2
PART B—CHILD HEALTH AMENDMENTS					
4211. Phased-in Mandatory Coverage of Children up to 100 percent of Poverty Level:					
(a) In General	8	75	125	175	240
(b) Outreach Applications	13	45	50	60	70
(c, d) Conforming Amendments	0	0	0	0	0
4212. Extension of Medicaid Transition Coverage	0	5	25	55	65
4214. Early and Periodic Screening and Diagnostic Services Defined	0	0	0	0	0
4215. Extension of Payment Provisions for Medically Necessary Services in Disproportionate Share Hospitals to Children Under 18 Years of Age	5	20	20	25	25
4216. Requiring "Section 209(b)" States to Provide Medical Assistance to Disabled Children Receiving SSI Benefits	3	15	15	15	20
4217. Mandatory Continuation of Coverage for Children Otherwise Qualified for Benefits Until Redetermination	2	5	5	10	10
4218. Optional Medicaid Coverage for Foster Children	5	20	20	20	20
PART C—COMMUNITY AND FACILITY HABILITATION SERVICES AMENDMENTS					
Subpart 1—Community Habilitation and Supportive Services	25	105	115	135	160
Subpart 2—Quality Assurance for Habilitation Facility Services	2	3	3	3	4
Subpart 3—Appropriate Placement for Individuals with Mental Retardation or Related Condition	1	2	2	2	3
Subpart 4—Payment for Community Habilitation and Supportive Services and Habilitation Facility Services	2	5	5	5	10
Subpart 5—Employee Protections and Miscellaneous	3	4	4	5	5
4248. Use of State Developmental Disabilities Agency in Certain Medicaid Administrative Functions	0	0	0	0	0

PART D—FRAIL ELDERLY COMMUNITY CARE AMENDMENTS					
4251. Community Care as Optional, Statewide, Service	35	145	165	180	200
PART E—HOSPICE COVERAGE					
4261. Mandating Hospice Coverage	1	5	5	10	10
PART F—MISCELLANEOUS					
4271. Amendments Relating to Nursing Home Reform	−3	0	0	0	0
4272. Medicare Buy-In Provisions	-(1)	1	5	7	10
4273. State Matching Payments for Voluntary and State Taxes	0	0	0	0	0
4274. Disproportionate Share Hospitals	0	0	0	0	0
4275. Miscellaneous Provisions:					
a. Fraud and Abuse Technical Amendment	0	0	0	0	0
b. Clarification of Coverage of Inpatient Psychiatric Hospital Services	0	0	0	0	0
c. Medically Needy Income Methodologies	0	0	0	0	0
d. HMO Provisions	0	0	0	0	0
e. Personal Care Services	0	0	0	0	0
f. NP's and CNS in Nursing Homes for routine visits	−1	−2	−2	−2	−3
g. Codification of Rehab Services	0	0	0	0	0
h. Study of Institutions for MD	0	0	0	0	0
i. Timely Payment for FOC Providers	0	0	0	0	0
j. Home and Community Based Waiver Clarifications	0	0	0	0	0
k. Spousal Impoverishment Clarifications	0	0	0	0	0
l. State Utilization Review Systems	0	0	0	0	0
m. Health Insuring Organizations	0	0	0	0	0
n. Day Habilitation Services	0	0	0	0	0
o. Miscellaneous Technical Corrections	0	0	0	0	0
Total for Medicaid Provisions	183	650	790	1,098	1,431
Subtitle D—Maternal and Child Health Program					
4301. Increase in Authorization of Appropriations	100	100	100	100	100
4302. Allotments to State and Federal set-asides	0	0	0	0	0
4303. Use of Allotments and Application for Block Grant Funds	0	0	0	0	0
4304. Reports	0	0	0	0	0
4305. Federal Assistance in Data Collection Mechanisms	0	0	0	0	0
4306. Development of Model Application Form for Maternal and Child Assistance Programs	0	0	0	0	0
4307. Research on Infant Mortality and Medicaid Services	0	0	0	0	0
Total for Subtitle D (Subject to Appropriations)	100	100	100	100	100
Subtitle E—Miscellaneous Health Related Provisions					
4401. Congressional Access to Information	0	0	0	0	0
4402. Vaccine Injury Compensation Technicals—Authorization Levels (Subject to Appropriations):					
a. HRSA Administration	2	2			
b. Attorney General	2	2			
c. United States Claims Court	2	2			
Total for Subtitle E (Subject to Appropriations)	6	6	0	0	0
Total (Direct Spending)	−342	330	392	640	887
Total (Subject to Appropriation)	166	194	220	100	100

[1] Less than $500,000 per year.

NOTE: All estimates contained in this document are subject to the following caveats: (1) All estimates are relative to the CBO February 1989 baseline and (2) studies which have no direct spending impact are not listed in this table.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(1)(4) of rule XI of the Rules of the House of Representatives, the committee makes the following statement with regard to the inflationary impact of the reported bill:

SECTION-BY-SECTION ANALYSIS AND DISCUSSION

Subtitle A—Medicare

Part A—Provisions Relating to Part B of Medicare

Subpart 1—Payment for Physicians' Services and Related Professional Services

Sec. 4001—Application of resource-based relative value scale to physicians' services

Section 4001 sets forth a systematic and comprehensive reform of the methodology used under Medicare to pay for physicians' services. This reform would be phased in over 4 years and would be budget neutral in each year, vis-a-vis the total expenditures that would have been made under Medicare for physicians' services in the absence of the reform. At the conclusion of the phase-in, physicians' services would be paid for under a fee schedule, rather than under the current "reasonable charge" methodology. The fee schedule would be based on a nationally uniform "resource-based relative value scale" ("RBRVS") and would use a national conversion factor that would be adjusted to take into account geographical variations in the costs of furnishing physicians' services.

This reform is one of the key elements in any strategy to improve the Medicare program. It will simplify the current, complex payment rules, thereby improving both the ability of the enrollees and physicians to understand the rules and the ability of the Medicare contractors to administer them. Moreover, by improving the equity among payments for these services, the committee believes this reform will contribute to a more appropriate mix and distribution of services than is now the case, which will greatly benefit the Medicare enrollees.

This reform, by itself, will not resolve broader, vitally important, issues regarding the appropriateness and effectiveness of the care delivered under Medicare or the continuing high rate of increase in Medicare expenditures. Additional measures are needed as part of a long term strategy, including those set forth in subtitle B of this bill dealing with research on patient outcomes and the development of clinical practice guidelines. Implementation of this reform can, however, facilitate the discussion and resolution of these issues, while helping to assure continuous access to quality care.

Background. Under current law, physicians services are typically reimbursed on a fee-for-service basis. The payment amount is based on a complicated method established when the program was enacted in 1965 and embellished over the years. Payment amounts are influenced by several factors, the most prominent of which are the historical pattern of charges billed by each physician and the Medicare economic index, which imposes a limit on the rate of increase in payment amounts from year to year.

The current methodology has numerous shortcomings and problems that are of grave concern to the committee. These include significant disparities among allowable payment amounts—for example, different payment amounts according to the geographical or institutional site of service, the physician specialty designation, or

the technological intensity of service—that cannot be rationally explained by analytically derived considerations. Rather, they are founded on historical patterns of charges, and do not reflect demonstrable variations in the cost of producing the service or the physician's skill.

These problems have been of concern to the committee for several years, as evidenced by numerous hearings, several mandated studies, and various legislative initiatives directed toward eventual systematic reform. These problems have also been well documented by several studies and published reports, by both governmental and non-governmental agencies and parties. Among the most notable governmental studies are those from the Office of Technology Assessment *(Payment for Physician Services: Strategies for Medicare Reform,* February 1986) and the Congressional Budget Office *(Physician Reimbursement under Medicare: Options for Change,* April 1986) and the three annual reports from the Physician Payment Review Commission (see, in particular, *Annual Report to Congress,* March 1989).

The most recent Physician Payment Review Commission (PPRC) annual report documents the progress that has been made in developing the concepts, data and analysis needed for comprehensive reform. It is also evident that a broad consensus has developed among many of the physician and patient organizations on the broad outlines for such reform. The committee, which for some time has viewed such a fee schedule as its goal for payment reform, is now in a position to formulate the fee schedule and begin making more substantial progress in achieving that goal.

Strategy for reform. The strategy embodied in this section is to enact legislation this year, and begin implementation on April 1, 1990, for a 4 year plan of transition to a fully implemented fee schedule based on a resource-based relative value scale. The committee recognizes that we do not yet have all the answers needed for full implementation of an RBRVS fee schedule. Research is continuing on some of the important issues involved. Many procedures have yet to be surveyed, or are scheduled for re-survey, by the research project at the Harvard School of Public Health that is developing the relative value scale. Further studies and analyses will be conducted by the PPRC and the Department of Human Services. However, it is also the committee's view that we know enough to begin implementation on a phased-in basis. It is further the committee's view that we may not be able to identify all the issues and questions until the Secretary has actually begun to construct and implement the fee schedule.

We have learned a great deal about physician payment reform over the last 5 years and we know enough to set our ultimate objective and begin promptly to make substantial progress toward that objective. Since the first adoption of the fee freeze in 1984, we have mandated studies by the Secretary of Health and Human Services and we have created the Physician Payment Review Commission to evaluate alternative reforms and make recommendations to us. The Commission's recent third annual report provided us with a comprehensive and thoughtful set of specific recommendations, which are supported by a number of important physician and beneficiary groups.

Moreover, by implementing this provision on a 4 year phase-in, we have time to resolve those questions for which we do not have complete answers, and we will be better able to answer them based on real experience gained during the initial implementation stages. Undoubtedly, there will be new issues raised during implementation that we have not anticipated. Over the next 2 years, there will also be generated better data and information, and more thorough analyses, to answer both currently identified issues and new issues that arise.

The committee also recognizes, however, that implementation in this manner, and this learning process, should be undertaken in a way that minimizes any risk of a serious mistake or an over-correction of current deficiencies. Physicians, patients and policy-makers all need time to understand the changes, to adjust to them, and to monitor the consequences carefully. It will be particularly important to monitor closely the potential effects on access to care, on quality of care, and on patient out-of-pocket expenditures. Changes in the mix, intensity and volume of services will also be of great interest to the committee.

The committee's strategy for minimizing errors and disruptions during the phase-in is to begin by making marginal adjustments in the current reasonable charge methodology, by reference to the ultimate objective of a RBRVS fee schedule. During the first 2 years of the phase-in, the Secretary of HHS would construct a "reference fee schedule", based on a resource-based relative value scale. However, payments would not be made directly under this reference fee schedule. Rather, it would be used to increase or decrease the current prevailing charge screens for individual services, depending on the relationship of those prevailing charges to the reference fee schedule. The reference fee schedule would, however, be as complete as possible in incorporating all of the essential components and elements of the final fee schedule, based on the best available information.

In order to expedite the initial implementation, and avoid delays that might ensue if the Department had to resolve various policy issues, the committee bill is quite specific in giving directions to the Secretary on how to begin the initial implementation in 1990. In particular, there are the three appendices attached to this committee report. The first one would identify the specific procedures for which the payment amounts would be adjusted and specify the relative value for each. The second appendix contains instructions on calculating the conversion factor so as to preserve budget neutrality and the third sets forth specific geographic adjustments in the conversion factor.

The committee bill leaves more discretion to the Secretary to resolve important issues after 1990. The committee expects the Secretary to consult widely with interested parties in resolving such issues and the normal requirements for notice and comment rulemaking would apply. The committee also anticipates that it will review this legislation periodically and is likely to amend and refine it to reflect subsequent research and the experience gained during the interim.

Application in 1990 to selected procedures. The committee recognizes that it is not practical at the time of the initial implementa-

tion to make adjustments in the payment amounts for all of the more than 7,000 procedure codes used in the Medicare program. Nor is it necessary to do so in order to make substantial progress on reform. Only those 389 procedures listed in Appendix A would be subject to adjustments under this reform in 1990. However, the procedures on this list represent many of the most significant services furnished under Medicare.

The list in Appendix A is based on the recommendations of the PPRC. It was developed with technical consultation with the Health Care Financing Administration and was subject to review by physician organizations. The list is comprised of services that were surveyed by the Harvard research team and services that are closely related to those surveyed. The specific relative values for the procedures on the list have been established by the PPRC based on the findings of the Harvard research team. Services were removed from the list whenever there was any indication of a problem or serious concern with the relative value assigned to it—such as changes in coding, insufficient or faulty data, or concern that a service was too dissimilar from those actually surveyed to warrant an extrapolation. As a result, the list represents services for which the committee has a high degree of confidence that the relative value is sufficiently accurate to begin the phase-in.

The list in Appendix A does not include services for several important medical specialties, which have not yet been surveyed by the Harvard research team or for which relative values could not confidently be determined. In particular, the schedule does not include radiology and anesthesia services. The Omnibus Budget Reconciliation Act of 1987 contained specific provisions, which originated in this committee, calling for fee schedules for those two specialties. The committee intends for the fee schedules developed under the 1987 legislation to be incorporated into the payment reform contained in this bill, beginning in 1991. This means that the work done by these specialties in developing the relative values among the services they perform should be retained to the extent consistent with overall reform. Adjustments will be made in the payment amounts for these services, as appropriate, to make sure that the payment levels for these services are consistent with their relative value compared to other services covered by the RBRVS fee schedule. The Secretary would be instructed by the bill to do this.

In the case of anesthesia services, the most practical way of doing this would appear to be to retain the relative value guide and make adjustments in the conversion factor. Since the preliminary analysis for anesthesia services indicates that they are overvalued relative to many other services, this would mean a reduction in the conversion factor.

For radiology services, it would be possible to do a similar adjustment in the conversion factors. However, this would mean that radiology services, for which the methodology of the fee schedule is otherwise identical to all services other than anesthesia, would have relative values that are not comparable and unique conversion factors. The committee concluded that the radiology fee schedule should conform as much a possible to the remainder of the fee schedule. Consequently, the bill would require the Secretary to use

the same conversion factor (and geographical adjustments) as he would for other services, and to adjust the recently constructed relative values for radiology services, as a class, to bring them into line with the RBRVS generally. In doing so, the Secretary would retain the relationships among the values assigned to radiology services under the current radiology fee schedule.

This method of treating anesthesiology and radiology places great reliance on the judgment of the physicians affected by the fee schedule for determining the relative weights to be accorded within the range of services they furnish. It also preserves the effort made in constructing the current fee schedules. The committee encourages the Secretary, the PPRC and other physician groups to use similar approaches in establishing relative values for the range of services not included in the survey conducted by the Harvard researchers. Such reliance on physician expertise will enhance the validity and acceptability of the fee schedule and is consistent with the development of the RBRVS to date.

Specialty differentials. As a general matter, the committee bill does not preserve the current specialty differentials that are frequently used by Medicare carriers under current law to pay differing amounts for apparently comparable services depending on the specialty designation of the physician furnishing the service. There has been considerable criticism about such specialty differentials, particularly since they are not applied in a consistent manner around the country, since physicians are permitted to designate their own specialty in the absence of definitive standards, and since it is difficult to prove whether the services are dissimilar. The PPRC recommended that specialty differentials be eliminated for like services and the bill does so.

It is the committee's view that those instances in which differential payments are warranted, based on the training and expertise of a specialist, can normally be accommodated with proper use of the procedure codes. Changes in the present codes may be necessary to implement this policy. There may be also particular instances, however, in which payment differentials are warranted and the committee expects the PPRC and the Secretary to review this issue carefully.

The general policy against specialty differentials does not mean, however, that specialty identifiers should be eliminated from claims forms currently submitted to Medicare. It will remain important to have claims data by specialty for several reasons. For one, treatment of malpractice expenses under the fee schedule may well be done on a specialty basis, when changes are made in 1992 as discussed below. Second, the volume and mix of services will be closely monitored along several dimensions, one of which should be by specialty. Third, specialty identifiers are important during utilization review to make sure payments for concurrent care are appropriately made. Fourth, the claims data generated by Medicare can be an important resource for valuable research, some of which is likely to require specialty designations.

Subsequent application and modification of relative values. After 1990, the reform would be applied to all of the procedures for which payment is made under Medicare. The Secretary would be responsible for establishing the relative values, based on the Har-

vard research project and the recommendations of the PPRC. The Secretary would also be responsible for keeping the relative values as current as possible and modifying them, as appropriate, to reflect changes in the practice of medicine, in the delivery of services, or in technological innovation. Two avenues are provided for making such changes. The Secretary, at any time during the year, could establish a new relative value for a service that had not had a value assigned. In addition, on an annual basis, the Secretary would be expected to review some or all of the existing relative values and revise them as appropriate. However, the bill is explicit in stating that such changes can only be done to reflect corrections in relative values. Adjustments could not be made solely for the purpose of achieving reductions in expenditures.

It is important to note that, under this method, there will be a single, uniform relative value scale applicable throughout the country. This will facilitate understanding of the relative values and the derivation of the fee schedule, as well as making subsequent updates and revisions easier. However, it should also be noted that this approach means that the geographical adjustments described below, to take account of regional differences in the cost of furnishing services, will be made on the conversion factors. Consequently, while there will be a national average conversion factor, there will not be a single, standard conversion factor for each fee schedule area. Rather, each service will have an individual local conversion factor. (An "average" local conversion factor can be computed for purposes of making general comparisons, but could not be used to construct the actual payment amount for any individual service under the local fee schedule.) While the complexity of this methodology may cause some confusion, the committee believes it is the most accurate and logical method of constructing the fee schedule and, overall, the most straightforward way of understanding it.

Adjustments in prevailing charges. The reference fee schedule would be used to adjust the prevailing charges otherwise calculated for 1990 for the services on the list in Appendix A. The amount of the adjustment would be one-fifth of the difference between the prevailing charge and the reference fee schedulee. This adjustment is substantial enough to result in significant progress toward the RBRVS fee schedule, without being so large as to cause a serious disruption or to run the risk of an erroneously large adjustment that will require subsequent correction. For many services, the actual amount of the adjustment will be less than 2 or 3 percent of the current payment amount.

Most services would be individually adjusted in this manner. However, this section sets out a special rule for office visits, hospital visits, consultations, and other services identified in the bill under the caption "evaluation and management services". These services would all receive an increase in the payment level. However, under the committee bill, they would all receive the same percentage increase, rather than individually calculated increases. This uniform percentage increase would be based on the weighted average of the increase each would have received under the statutory formula. The reason for this special treatment is to take into account concerns expressed by the PPRC and others about the accuracy of the relative values for some of these services, due to am-

biguities in the definitions and inconsistencies in the coding used by physicians for these services.

The committee bill instructs the Secretary to revise the definitions and coding for these services so that individual adjustments and payments can be made accurately in the future. The bill instructs the Secretary to apply these revisions beginning January 1, 1992. It also instructs the Secretary, in making the revisions, to take into account the time spent in furnishing such services. Although time is arguably an implicit element in the current definitions of visits and similar procedures, the Harvard research team and the PPRC concluded that there is great variation among physicians in how they interpret the current definitions. Both also concluded that explicit treatment of time would clarify the definitions and make their application more consistent. The committee notes, however, that time should not be the exclusive factor and that the intensity, risk, or other factors will also continue to be important. For some procedures in particular, such as emergency room services, giving appropriate weight to factors other than time will be important in arriving at a valid relative value. The PPRC and the American Medical Association are currently undertaking a joint project on these issues, and the committee expects the Secretary to take the results of that project into consideration in carrying out this provision. As a related matter, the bill delays the requirement in the Omnibus Budget Reconciliation Act of 1986 that the Secretary consolidate procedure codes, so that such a requirement would not interfere with this project.

Until these improvements in the definitions and coding of evaluation and management services are ready in 1992, using the group average will avoid any serious miscalculation for any of these services, while assuring that all of them receive a significant increase. The increase is expected to be approximately 5 percent in 1990, which is in the same range as the projected Medicare economic index for that year.

This same approach of a marginal adjustment in prevailing charges would be used in 1991, the second year of the transition, except that all 7,000-plus procedure codes would be adjusted and the relative values used in the reference fee schedule would be assigned by the Secretary of HHS, based on the Harvard study and the recommendations of the PPRC. In the second year, the adjustment would be one fourth of the difference between the prevailing charge for that year and the reference fee schedule amount.

For 1991, the Secretary would not recalculate prevailing charges in the normal manner, to reflect the customary charges, for the services that were listed in Appendix A. Rather, the prevailing charge for these services would be the adjusted prevailing charge for 1990 further adjusted by the Medicare economic index for 1991. This will make implementation in 1991 easier, less costly, and less confusing. Customary charges would still have to be calculated for 1991, however, since the current payment methodology would still be in effect. In addition, prevailing charges would be calculated in the normal manner for services not on the list.

Elimination of customary charges. In 1992, customary charges would be dropped altogether and would not have to be calculated. The customary charges would not be needed in 1992 in order to de-

termine prevailing charges, because the prevailing charges in 1992, for purposes of making fee schedule adjustments, would simply be the adjusted prevailing charges for 1991 updated by the Medicare economic index. Moreover, customary charges would no longer be needed as a fee screen, since the reform would switch in 1992 from the current reasonable charge methodology to a fee schedule.

By 1992, the third year of implementation, the level of confidence in the fee schedule should be sufficient, when combined with any refinements made by the Congress in the interim, to permit payments to begin to be made under a fee schedule. However, since the amount of increases and decreases in payments may still be substantial, payments during the third year of transition would be made under an adjusted fee schedule. The dollar amounts under the adjusted fee schedule would be derived by splitting the difference between the reference fee schedule and what the prevailing charges (calculated as discussed above) would have been.

When the methodology for payments is changed in 1992 from the current reasonable charge method to the fee schedule, Medicare would pay 80 percent of the fee schedule amount or 80 percent of the physician's actual charge, whichever is lower.

Conversion factors. The other critical component of the fee schedule, in addition to the relative value scale, is the conversion factor. The conversion factor is expressed in terms of dollars per unit of relative value. The fee schedule is constructed by multiplying the relative value for each service by the conversion factor.

The committee bill would require the Secretary to calculate a national conversion factor each year, in a budget neutral manner. It would also require the Secretary to adjust this national conversion factor among designated geographical areas (labeled "fee schedule areas" in the bill) to take account of differences among such areas in the cost of furnishing services.

The committee bill assumes that measures other than this reform will be taken to achieve whatever savings are required under the instructions in the Budget Resolution. For 1990, in particular, such savings are achieved primarily by a one-year freeze in the Medicare economic index (see section 4002, below). It is important to the successful implementation of this reform that it not become a vehicle for budget reductions or be viewed as a means of achieving some desired level of spending for Medicare. At the same time, however, the committee does not want this reform to be the cause of an increase in volume or higher expenditures.

The Secretary would be responsible for calculating the appropriate conversion factor that achieves budget neutrality, based on the best data available information regarding the volume and mix of services that would be furnished under the reform and that would have been furnished in the absence of reform. One of the critical questions in this matter is how the payment reform will influence the volume and mix of services as physicians and patients react to changes in payment levels. There is a good deal of speculation about what will happen, but very little reliable information.

For the initial implementation in 1990, the committee bill would give the Secretary explicit instructions on how to take such behavioral responses into account. These instructions are contained in Appendix B. They were prepared for the committee by the Congres-

sional Budget Office ("CBO") and are based on the best information available at this time. The model used by CBO for this purpose is based heavily on analyses of the experience in the 1970's when carrier locales were consolidated and Medicare fees were extensively revised in the State of Colorado. The analysis done by CBO, using 1986 data and the specifications for payment reform set forth in the committee bill, indicates that the adjustment needed to account for such behavioral response would be very small—on the order of a fraction of 1 percent. The bill would require the Secretary to use the same analysis undertaken used by CBO, as specified in Appendix B, in calculating the conversion factor for 1990. The result might vary to some small degree when claims data for 1987 is used, rather than data for 1986, but the adjustment would still be expected to be a fraction of 1 percent.

For 1991 and subsequent years, the Secretary would be responsible for calculating the budget neutral conversion factor, taking into account the recommendations of the PPRC, the percentage increase in the MEI, and projected changes in the volume and mix of services. The Secretary would be required to submit a report to the Congress explaining his analysis of such projected changes. The Secretary's calculations would be based on the projection of what the aggregate expenditures would be under the payment reform and projections as to what they would have been in the absence of payment reform. This provision would not authorize the Secretary to adjust the conversion factor for 1991 (or for any subsequent year) in order to recover amounts that were expended in the previous year in excess of the amount originally projected. The Secretary could, of course, correct his analytical model to avoid subsequent inaccuracies in his projections, but could not recoup amounts previously expended. The Secretary would also be expected to seek to identify changes in the volume and mix of services that would have occurred even in the absence of payment reform—such as changes due to technological innovation or improved utilization review—and to exclude these changes from the adjustments made under this section.

Geographical adjustments. Once a national, budget neutral conversion factor was calculated, the Secretary would adjust this for each fee schedule area, to take account of differences in the value of the resources used in furnishing services. For 1990 and 1991, these fee schedule areas would be the current carrier locales, because the capacity does not currently exist to use other areas. However, the committee believes that it would be more appropriate to use either statewide fee schedule areas or to use metropolitan statistical areas along with combined non-MSA areas. Further analysis on these, and possibly other alternatives, will be undertaken by the PPRC and the Secretary, so that a decision can be made at a later date. The bill states that the Secretary will make a decision prior to 1992, but it is the committee's expectation that the Congress is likely to make such a decision before that date.

The geographical adjustment for 1990 and 1991 would be applied to each of the two components of the RBRVS—one representing the "practice expenses" (the costs a physician must incur in producing a service) and the other representing the physician's personal resources. (The bill uses the term "physician work effort" for the

second component, although some persons prefer the term "earnings".) For this purpose, practice expenses include such items as office rent, wages of personnel, equipment, and the like, but do not include the physician's own earnings or his own fringe benefits (including any automobile for which expenditures are charged to his practice). Malpractice costs would initially be included in the practice cost component, but the bill would instruct the Secretary to separate malpractice from the remainder of practice costs by 1992 and adjust it by a unique index. Thus, beginning in 1992, there would be three components to the geographic adjustment.

The relative value for each service would be divided into two components, to reflect the particular mix of practice expenses and physician work effort for that service. (This split is specified in Appendix A for purposes of services that will be subject to adjustments in 1990.) The national average conversion factor is then split into two components, service code by service code, to reflect the same ratio between practice costs and physician work effort. Each component of the conversion factor would then be adjusted by an index, consisting of weighting factors that take account of geographical variations in the costs represented in the component. There is one index for the practice expense component and another for the physician work component.

The two indices to be used for this purpose in 1990 are specified in Appendix C. Appendix C was developed by the PPRC at the committee's request, and is based on a research conducted by the Urban Institute under contract with the Health Care Financing Administration. For 1991 and thereafter, the Secretary would be responsible for refining this index, or developing a new one, as appropriate.

The index used to adjust the practice expense component is based on data from the Bureau of Labor Statistics, from the Department of Housing and Urban Development, and from comparably reliable sources of information regarding variations in the costs of office space, salaries of nonphysician employees, and medical equipment. The index developed by the Urban Institute was been reviewed and widely accepted by other researchers and policy analysts. The committee notes that this practice expense index would also be used to adjust the so-called technical component of services, such as radiology services, when these are identified and reimbursed separately from the professional component.

The index used to adjust the physician work effort component is an adaptation of the index developed by the Urban Institute. It is based on data from the 1980 Census on the incomes of professionals around the country. This is the best proxy currently available to assess the variation among geographical areas in the valuation placed on the physician's time and effort. The index initially developed by the Urban Institute took the variations in such professional incomes fully into account. The committee, however, requested the PPRC to develop an adjusted index that reduces by half the magnitude of the adjustments that would be made under the original index.

The PPRC, in its annual report for 1989, recommended that the physician work effort component of the fee schedule not be adjusted at all for geographical variations, on the grounds that the physi-

cian's time and effort should be given the same valuation everywhere in the country. The committee does not agree with this recommendation. The committee recognizes that the cost of living varies around the country and that other professionals are compensated differentially, based on where they perform their services. The committee is concerned that, if no adjustment is made in the physician work effort component, fees in high cost areas may be reduced to such an extent that physician services in such areas would become inaccessible. The committee is also concerned, however, that a full adjustment of this component, in accord with the index developed by the Urban Institute, would be disadvantageous to the low valuation areas and would not serve the committee's policy goal of fostering a better distribution of physician personnel. Fees in those areas might be too low to attract physicians and to resolve problems of access that have occurred.

The index chosen by the committee tries to balance these concerns. It makes an adjustment in the physician work effort component, but cuts the impact of the original Urban Institute index in half. Arithmetically, this is achieved by adding 1.00 to each index value derived by the Urban Institute, and dividing the sum by two. For example, a fee schedule area that had a physician work effort component index value of 1.12 under the original Urban Index would have an index value of 1.06 under the committee's index. Similarly, an area with an original value of 0.94 would have a value of 0.97 under the committee index. In 1991, and for subsequent years, the Secretary would establish the index, using this same approach of cutting in half the effect of an index that took variations in professional incomes fully into account.

Beneficiary protection against excessive balance billing. The committee bill also contains a provision designed to protect beneficiaries against excessive balance billing. The current MAAC limits would expire on December 31, 1990, and would not be renewed. Beginning January 1, 1991, physicians who had not signed a participating physician agreement would be allowed to charge up to 120 percent of the Medicare allowable charge. In 1990 and 1991, this Medicare allowable amount would be the prevailing charge, as adjusted in accordance with the reform set forth in this section. Beginning in 1992, it would be the fee schedule amount.

Secretarial monitoring of impact of fee schedule reform. The committee recognizes that it will be important to have extensive and reliable information, on a timely basis, about the effects of this reform. Accordingly, the Secretary would be required to monitor the effects of this reform and report annually to the Congress. The committee is particularly concerned about the effects of the reform on the rate of assignment and the burden of balance billing placed on beneficiaries, as well as changes in the mix and volume of services furnished. The committee is advised that the Health Care Financing Administration is proposing to implement a new Current Beneficiary Survey. Such a survey would facilitate the implementation of this provision and this reform, and the committee urges the Secretary to institute the survey as promptly as possible. In addition to the annual reports called for in the bill, the committee anticipates making specific requests to the Secretary and the PPRC from time to time for additional information and analysis.

Change in participating physician agreements. Physicians are normally given a period of time before the start of the calendar year to sign a participation agreement for the coming calendar year. In order to make an informed decision on whether to sign the agreement, a physician should know what the Medicare payments will be for the services he furnishes and the upper limit on what he is permitted to charge a patient if he does not sign the agreement.

Because the adjustments in the prevailing charges would not be effective until April 1, 1990, and information about the adjustments will not likely be available before January 1, the bill revises the normal sign-up period for 1990. Physicians would be given a sign-up period prior to April 1, 1990, after the adjustments in prevailing charges and recalculation of the physician's MAAC limits have been made. The normal sign-up during November 1989 would be eliminated. Since section 4002 would essentially result in a 3-month freeze in the current fees, and since there would only be a 3-month period before the fees changed, it does not seem necessary to go through that sign-up period. Current participation agreements would be extended for 3 months, but physicians with a current agreement who wished to terminate it on January 1, 1990, would be given the opportunity to do so. Physicians who do not have a current agreement would not be given an opportunity to sign one just for the 3-month period January through March 1990. They would have to await the sign-up period for April 1990.

Various other technical and conforming changes are made in the bill, including adjustments in payments to other health care practitioners whose payment methodologies are dependent on payments for physician services.

The committee recognizes that the reform set forth in this section is by no means the panacea for solving all the concerns being raised about the Medicare program or the health care delivery system. We must continue to pursue a coordinated approach that entails improved policies on graduate medical education and health manpower, along with enhanced research on technology assessment, quality assurance and the effectiveness and appropriateness of health care services. We also need improvements in peer review and utilization review. The committee intends to continue reviewing and seeking improvements in these related areas of health policy.

Sec. 4002—Freeze in Medicare Economic Index during 1990

The Medicare economic index is essentially an inflation adjustment that acts as a restraint on the extent to which the "prevailing charges" recognized by Medicare as reasonable may increase from year to year. It was initially enacted by the Congress in 1972 and is based on the costs of a representative set of inputs, including salaries and earnings, that go into furnishing physician services.

The MEI is normally calculated each year by the Secretary and is announced in October of each year for the following year. During the last 5 years, however, the Congress has been statutorily establishing MEI increases lower than would otherwise be the case, as a means of achieving budget savings. The Congressional Budget Office estimates that, in the absence of Congressional action, the

MEI for 1990 would allow a 5.3 percent increase in prevailing charges.

The committee bill would eliminate the MEI increase for calendar year 1990. This is the principal Medicare savings item in the committee bill, in response to the instructions in the budget resolution for fiscal year 1990.

The committee is interested in pursuing fundamental reform in Medicare payments for physician services, as set forth in section 4001, as expeditiously as possible. This provision, eliminating the MEI for 1990, is the simplest and most straightforward means of achieving savings. The committee has voiced displeasure in the past at provisions such as this and has previously attempted a different, more targeted approach to combining savings measures with efforts to achieve policy objectives. In this instance, however, this provision allows the Secretary to pursue the implementation of payment reform without the distraction of first implementing complicated savings provisions. The payment reform provisions, which would be implemented in a budget neutral manner, would promote the policy goals of increasing the payments for undervalued services and reducing those for over-valued services, thereby improving the mix and distribution of services.

Taken in conjunction with the payment reform provision in section 4001, this provision would result in a 3 month freeze on all fees, from January 1 through March 31, 1990. Fees would then be adjusted under the payment reform.

As noted previously, in the description for section 4001, physicians who currently have participating physician agreements due to expire on December 31, 1989, would be given an opportunity to become a non-participating physician on that date, under the terms of section 4001. If the physician did not request that his participation agreement be terminated, it would be extended through March 31. All physicians would be given a new opportunity prior to April 1 to sign a participation agreement, but the sign-up period due in November 1989 would be eliminated.

Sec. 4003—Payment for Radiology Services

The Omnibus Budget Reconciliation Act of 1987 called for the Secretary, in consultation with the physician groups affected, to establish a relative value scale and a fee schedule for radiologists' services. These tasks have been completed and the fee schedule was implemented earlier this year. While many aspects of the fee schedule have been implemented in a satisfactory way, two problems have arisen that are addressed in this provision.

The committee, in initiating the fee schedule proposal in 1987, anticipated that the Secretary would develop a method of adjusting the fee schedule to reflect geographical differences in the cost of furnishing services, in a manner similar to that set forth in section 4001 of this bill. This was not done. Rather, the conversion factors used to derive the fee schedule in each area were based on prior charges submitted by physicians practicing in the area. As a result, the fee schedule incorporated undesirable geographical variations that existed prior to the fee reform.

The committee bill would require the Secretary to calculate a national average conversion factor and to adjust that factor by the

geographical indexes developed under section 4001. This reform of the radiology fee schedule would be phased in over 2 years, by setting the fee schedule amounts in 1990 at half the difference between what they would have been under this method of geographic adjustment and what they would have been under the current fee schedule. In 1991, they would be fully adjusted in accordance with the geographic indices set forth in section 4001. The provision would be implemented in a budget neutral way. Thus, in both years, the conversion factor is to be calculated by the Secretary so that total payments under this provision are the same as they would have been in the absence of this change.

A second concern is that nuclear physicians have been subjected to an inordinate decrease under the new fee schedule. The committee is advised that the fee schedule did not adequately account for the differing manner in which nuclear physicians furnish services subject to the fee schedule. The committee is also advised that efforts are being made by the Secretary, the radiologists, and the nuclear physicians to resolve this matter. The committee bill would exempt nuclear physicians from the fee schedule for 1 year, in order to permit a resolution to be worked out.

Sec. 4004—Payment for Anesthesiology Services

Anesthesiology fee schedule. Anesthesiology services are currently paid by Medicare under a unique system. Services are assigned "base units", which vary according to the complexity and risk involved in each procedure. In addition, the time spent caring for the patient is counted, typically in 15 minute time units. (Thirty minute time units are used if an anesthesiologist is supervising a nurse anesthetist who is not employed by the anesthesiologist.) The actual charge for anesthesiology services is calculated by adding the base units and time units together, and the multiplying the sum of those by a conversion factor. The Omnibus Budget Reconciliation Act of 1987 required the Secretary to develop a uniform relative value guide for base units under this system, which would be consistently applied throughout the country with appropriate conversions factors.

The time element of this methodology is currently counted in whole units and is always rounded upward. Thus, if the anesthesiologist spends any portion of a time unit with the patient, a whole time unit is counted. Under this approach, for example, any amount of time between 16 minutes and 30 minutes would be counted as two time units. This clearly inflates the time units and the corresponding charges for these services.

The committee bill would require that time be counted using fractional time units, based on the actual time spent on patient care. For example, 16 minutes would be counted as one and one-fifteenth time units, rather than two whole time units.

CRNA fee schedule. The Omnibus Budget Reconciliation Act of 1986 included a provision, which originated in this committee, authorizing payments for certified registered nurse anesthetists under a fee schedule. Among the other statutory elements applicable to this fee schedule were the requirements that the fee schedule be based on the costs incurred by hospitals in employing CRNA's and that adjustments be made in the fee schedule, as necessary, to

achieve budget neutrality compared to what payments would be in the absence of this reform.

The Secretary has developed the CRNA fee schedule and has published it for public comment. Because of the budget neutrality requirement, the conversion factors used in the fee schedule are considerably lower than was expected, in comparison to hospital costs.

The committee bill would raise the conversion factors, to make them more commensurate with the data from the hospital cost reports.

The bill would also preclude a surgeon from billing for the medical direction of a CRNA. This practice is currently permitted by some of the Medicare contractors, but not by others. The Department of Health and Human Services has proposed having all contractors conform by not permitting such billing. The committee concurred with the reasoning that a physician should not be billing for anesthesia supervisory services performed simultaneously with furnishing surgical procedures.

In addition, the bill would extend and expand the authority of small rural hospitals to be reimbursed for employing a CRNA. Under current law, if the CRNA (or CRNA's) employed by the hospital agrees not to file a claim under the fee schedule, a hospital that previously received cost reimbursement can elect to continue that arrangement. This permits the hospital to retain the services of the CRNA, even though the number of services performed at the hospital is too few to generate sufficient revenues under the fee schedule to support a CRNA. The current provision is limited, however, to hospitals performing 250 or fewer procedures requiring anesthesia services per year and it would expire at the end of 1991. These limitations have hindered the ability of some rural hospitals to sustain access to surgical procedures. The committee bill would increase the qualifying threshold to 500 procedures per year and would make the provision permanent.

Sec. 4005—Payment for Pathology Services

Pathology services are currently reimbursed under the reasonable charge methodology generally applicable to other physician services. There have been a number of serious concerns raised, however, regarding the appropriateness of those charges, because of various legislative and regulatory revisions implemented over the last few years. The Omnibus Budget Reconciliation Act of 1987 contained a provision, which was initiated by this committee, requiring the Secretary, in consultation with physicians performing pathology services, to develop a relative value scale and a fee schedule for pathology services. The provision did not authorize the Secretary to implement the fee schedule. Rather, it required him to report to the Congress, which would then have to enact further enabling legislation before the fee schedule could be implemented.

The Secretary has developed a fee schedule for pathology services, based on the reasonable charges for pathology services contained in Medicare claims data. This fee schedule is currently under review by the physician community, prior to submission to the Congress. Meanwhile, the Harvard research project developing a resource-based relative value scale, described above in section

4001, has surveyed some of these pathology services and concluded that further review is necessary before satisfactory results are available.

The committee bill would authorize implementation of the fee schedule on January 1, 1989, and would also require that geographic adjustments in a national fee schedule be made in a manner comparable to that made under section 4001. The committee recognizes that further analysis and development of this fee schedule may be necessary between now and the date of implementation. The committee intends to review carefully the response of the physician community to the Secretary's proposed fee schedule and to monitor the issues closely before implementation. The committee urges the physicians who would be affected by this fee schedule to work closely with the Secretary and the Physician Payment Review Commission to develop a relative value scale that reflects its best judgment of the relative resource costs of these services.

Sec. 4006—Waiver of Liability Limiting Recoupment in Certain Cases

During the middle 1980's, the Health Care Financing Administration (HCFA) required all Medicare carriers to adopt a nationally uniform system of coding known as the HCFA Common Procedure Coding System (HCPCS). The carriers had previously been using a variety of different coding systems for processing claims for physician services. Most carriers were able to convert to the new system without encountering serious problems with inappropriate payments. However, the conversion did cause problems in some instances, particularly when it was not clear what new code was the most appropriate substitute for the prior code.

When this problem arose in the State of Texas, the carrier implemented statewide fees, rather than different fees in each of the carrier locales, for some services for a substantial period of time. HCFA later concluded that this was incorrect and that a overpayments had been made in a significant number of cases. HCFA has been seeking recoupment of these overpayments.

The committee bill would preclude this recoupment, whether it was attempted by means of a direct recoupment action against a physician or beneficiary or by withholding funds from payments that are subsequently due the physician or beneficiary. The bill would accomplish this by applying the provisions of section 1870(c) of the Social Security Act to these cases. Under that provision, the physicians and patients who received overpayments under the statewide fee schedule, during a specified period of time, would be deemed to be "without fault" and, therefore, a successful recoupment procedure could not against them under section 1870. The committee believes that the Secretary should also make reasonable efforts to repay those individuals from whom a recoupment has already been effected.

Subpart 2—Payment for Other Services

Sec. 4011—Durable Medical Equipment

The Omnibus Budget Reconciliation Act of 1987 contained a comprehensive reform of the methodology used under Medicare to pay

for durable medical equipment, prosthetics and orthotics. The provision, which originated in this committee, required the Secretary to develop fee schedules for these items. The items subject to this provision were divided into six different categories, with instructions for each category on how the fee schedules were to be derived. The committee bill makes a number of refinements in the fee schedules developed under this provision.

Durable medical equipment fee schedules. For two of the six categories (including most durable medical equipment and most prosthetics and orthotics), the 1987 legislation provided for a gradual phase-in of regional payment rates, beginning in 1991 and concluding in 1993. The purpose of these regional rates was to smooth out unwarranted variations in fees that might occur from State to neighboring State. It also set upper and lower bounds on the amount by which the fee schedule amount in any fee schedule area could depart from the average of the amounts for all fee schedule areas. This limit would first go into effect in 1991 and would tighten further in 1992.

Now that these fee schedules have been developed, sizeable variations have been revealed. The committee bill would accelerate the application of these provisions that limit the degree of variation. It would start the phase-in of regional rates in 1990, instead of 1991, and would conclude in 1992, instead of 1993. It would also move the initial application of the upper and lower bounds to 1990 rather than 1991, and would narrow further the band of allowable variation.

Enteral and parenteral equipment. The 1987 reform exempted enteral and parenteral nutrients, supplies and equipment from the new fee schedule. It did so on the grounds that these had previously been legislatively subjected to the so-called "lowest charge level" payment methodology by the Omnibus Budget Reconciliation Act of 1986, and that provision appeared to be working satisfactorily.

The Health Care Financing Administration (HCFA) has advised the committee, however, that the equipment used in furnishing these services is comparable to other prosthetic devices and durable medical equipment for which payment is made under the new fee schedule. HCFA has urged that such equipment be reimbursed under the fee schedule, which should result in some savings to the program. The committee bill would remove enteral and parenteral equipment from the exception, which would place such equipment under the appropriate category of the fee schedule established under the 1987 legislation. Nutrients and supplies would remain subject to the lowest charge level provision.

Reductions in selected items. The Inspector General for the Department of Health and Human Services has identified serious concerns regarding Medicare payments for selected items of durable medical equipment, including seat lift chairs, power operated vehicles, and transcutaneous electrical nerve stimulators. The Inspector General's findings indicate there is substantial over-utilization of these items. The committee bill would reduce the fee schedule payment amounts for these items by 15 percent. While the committee acknowledges that a comprehensive response to these concerns might appropriately include additional strategies, such as stronger utilization review and payment safeguards, it seems clear to the

committee that a reduction in fees is likely to reduce the incentives and opportunities for abuse identified by the Inspector General.

Power driven wheelchairs. Power driven wheel chairs are currently paid for in the same manner as most durable medical equipment, which is on a rental basis for up to 15 months. This method does not well serve the needs of the patients who need these items. Typically these are patients who are severely handicapped and heavily dependent on their wheelchairs. The power driven wheelchairs used by them are normally built to the specifications suitable for each individual patient. In addition, they require frequent and substantial maintenance and repairs, and have to be replaced after a few years of use. It seems more appropriate for this item to be paid on a purchase basis in most cases, rather than on a rental basis. However, the Health Care Financing Administration has concluded that this cannot be done consistent with the current definitions and conditions of the purchase categories of the 1987 fee schedule reform.

The committee bill would amend the 1987 reform to include wheelchairs under the category of "routinely purchased durable medical equipment". This would allow them to be reimbursed under Medicare on either a rental or purchase basis, subject to the proviso that total rental payments for a particular item furnished to a specific patient may not exceed the allowable purchase price.

The committee is apprised that available data on previous charges and payments may be flawed, due to inconsistencies in coding and other carrier practices. The committee will continue to review this and urges the Secretary to use appropriate means of analyzing the data to assure that payment levels are reasonable.

The committee also understands the Secretary has adopted policies that provide for appropriate payments for maintenance and repair of items covered under the "routinely purchased" category. Although such payments are not explicitly authorized under this provision, it is the committee's expectation that such payments will be authorized.

Ostomy supplies. Ostomy supplies are frequently used by patients receiving home health services. These are low cost, disposable supplies that are used and replaced on a frequent basis by patients. Prior to the 1987 reform, the home health agency typically provided such supplies and was reimbursed on a cost basis. The patient did not incur any deductible or coinsurance under these circumstances. Under the 1987 reform, these supplies are now reimbursed under the fee schedule. This means that itemized claims must be submitted by or on behalf of the patient and the patient is responsible for the regular Part B deductible and coinsurance amounts. This appears to be unnecessarily cumbersome and difficult for patients, given the nature of these supplies.

The committee bill would reinstate payment for these items through the home health agency. It would, moreover, go a step further. It would not only include these items under the definition of home health services, but it would also require that any home health agency providing services to a patient who needs such supplies must offer to furnish them as part of its home health services. Payment would be made to the home health agency on a cost basis.

Because these supplies would be a home health service, the patient would not be responsible for deductible and coinsurance.

There will continue to be some beneficiaries who need these supplies, but who are not receiving home health services. In those cases, reimbursement would continue to be made under the fee schedules developed under the 1987 reform.

Sec. 4012—Clinical Diagnostic Laboratory Services

Clinical diagnostic laboratory tests are currently reimbursed under Medicare on the basis of statewide fee schedules. This reform was originally enacted in the Deficit Reduction Act of 1984 and has been revised several times during subsequent budget reconciliation acts. The committee bill contains further refinements in the current fee schedules.

Limit on payment amount. The current statewide fee schedules are subject to an upper limit. Medicare will not pay more for a given test than the median, for that test, of all of the statewide fee schedules. Analyses of these fee schedules undertaken by the HHS Inspector General and the Comptroller General indicate that this limit could be moderately reduced without creating a substantial risk of impairing access to quality service. Accordingly, the committee bill, in response to the instructions of the budget resolution, would reduce the limit to achieve additional savings. The limit would be reduced to 95 percent of the median of the statewide fee schedules. The committee bill would retain the statutory annual update, which is equivalent to the Consumer Price Index and is estimated by the Congressional Budget Office to be approximately 4.6 percent for 1990.

The committee also reviewed the reasonableness of Medicare payments for panels of tests (several tests done for a given patient simultaneously on a single laboratory instrument) and for test profiles (several tests ordered and performed concurrently, as a package for a given patient, using various testing methods and instruments). Studies by the HHS Inspector General have raised questions about these techniques resulting in unnecessary utilization and excessive payments. The committee urges the Secretary to review the practice of test panels and test profiles, with regard to the appropriateness of both utilization and payment amounts, and to take appropriate action under existing authority or make recommendations for legislative amendments.

Restriction on payment to referring laboratory. The 1984 reform included a provision, commonly referred to as "direct billing", which required that, as a general rule, payment for laboratory services could only be made to the laboratory that actually performed the test. A few exceptions to this general rule were provided, including one authorizing payment to a laboratory that had referred a sample to another laboratory. This exception was intended to deal primarily with tests done by rural hospitals, or by other small laboratories, that performed most of the testing for which they filed claims but did not have the capacity to do some particularly difficult or sophisticated tests.

The committee has been advised that some laboratories have been taking advantage of this exception in a manner that was not intended. Parties have created laboratories that have only a limit-

ed capacity to do testing, or indeed have virtually no capacity to do testing, but that act as conduits for referrals to other laboratories. This arrangement allows the owners and operators of the referring laboratory to obtain substantial discounts from the testing laboratory or to make other financial arrangements so that, even though there is a limit on Medicare payments, the referring laboratory is able to make inappropriate profits on testing done for Medicare patients. This is likely to be an inducement for unnecessary testing and contravenes the intent of the direct billing requirement. This is not acceptable to the committee.

The committee bill would narrow the current exception, so that it would apply only to laboratories that are an integral part of a rural hospital and to other laboratories that referred no more than 30 percent of their tests per year to be done by other laboratories. The committee concluded that the exception for rural hospitals is essential in order to assure appropriate access to laboratory testing in such communities. It also concluded that limiting the exception to laboratories that do at least 70 percent of the testing for which they submit claims on their own premises would assure that the laboratory is a *bona fide* facility and is not merely a shell operation created to generate a profitable practice. This provision would not affect in any way the current statutory provisions prohibiting kickbacks or payments made to induce the referral of items or services for which payment may be made under Medicare (see 42 U.S.C. 1320a-7b).

Repeal of nationwide fee schedule. The 1984 reform included the requirement that the Secretary implement a uniform nationwide fee schedule, to replace the statewide fee schedules, within 3 years. That requirement has been postponed repeatedly in subsequent budget reconciliation acts. The Secretary was also instructed to submit a report to Congress on how such a nationwide fee schedule would be developed. That report has not been submitted. In the meantime, the Congress has imposed, and periodically reduced, the upper limits on fee schedule amounts discussed above, while allowing increases in the lower fees.

The committee bill would repeal the instruction to the Secretary to implement a nationwide fee schedule. The committee will continue to review the merits of such a fee schedule and how it might be accomplished, including a review of the Secretary's report if that is eventually submitted, with a view towards possible subsequent legislation.

Repeal of Medicare certification of "high volume" physician office laboratories. The Omnibus Budget Reconciliation Act of 1987 included a requirement that the Secretary, by January 1, 1990, begin certifying physician office laboratories that perform more than 5,000 clinical diagnostic laboratory tests per year. Physician office laboratories (POL's) were previously exempt from both the licensure requirements of the Clinical Laboratory Improvement Act of 1967 and the certification requirements applicable to other laboratories under Medicare.

The 1987 amendment reflected Congressional recognition that POL's have been growing rapidly, in both number and sophistication, and have been furnishing an increasingly significant proportion of laboratory testing. There was increasing concern that they

20-456 O - 89 - 2

might not be furnishing services of acceptable quality. The 1987 amendment did not, however, specify what certification standards should apply to POL's under this required certification. It was not this committee's understanding that all POL's would necessarily be subject to the identical standards applicable to independent laboratories and hospital laboratories.

Last year, the committee developed a comprehensive program to improve the reliability and accuracy of clinical laboratory services. (Clinical Laboratory Improvement Amendments of 1988, Public Law 100-578). That act sets forth detailed requirements for Federal certification of all laboratories, including POL's. These provisions, most of which are also effective on January 1, 1990, apply differential standards to laboratories, depending on the nature of the testing being done in the laboratory, but do not otherwise differentiate between independent laboratories and POL's. The committee believes that these 1988 amendments establish a comprehensive regulatory program that supersedes any other standards. The 1987 reconciliation provision requiring Medicare certification of high-volume laboratories is now superfluous and is also potentially confusing, should it be interpreted as requiring POL's to comply with standards different from those in the 1988 legislation. The committee bill, therefore, repeals the 1987 provision.

Sec. 4013—Reduction in Capital Payments for Outpatient Hospital Services

The expenses incurred by hospitals for capital are currently reimbursed by Medicare on a cost basis, in proportion to the number of patient days or services furnished to Medicare enrollees. Costs attributable to inpatient services are reimbursed under Part A of the program, while costs attributable to outpatient hospital care are reimbursed under Part B.

Under the Omnibus Budget Reconciliation Act of 1987, Medicare payments under Part for capital-related expenses have been reduced by 12 percent in fiscal year 1988 and by 15 percent in 1989, but payments under Part B have continued to be made at 100 percent of Medicare's proportional share of capital costs. In response to the instructions of the budget resolution, the committee bill would reduce payments for hospital outpatient capital costs by 15 percent, beginning with cost reporting periods (or portions thereof) beginning on or after October 1, 1989. An exception would be made for sole community hospitals, which would continue to be reimbursed for 100 percent of their outpatient capital costs.

Sec. 4014—Federally Qualified Health Center Services

Community health centers and migrant health centers receiving grants under sections 329 and 330 of the Public Health Service Act are also currently able to receive Medicare payments for services furnished to Medicare enrollees. There is no explicit statutory authority for such Medicare payments, however. Payments are made under regulations and program instructions issued by the Health Care Financing Administration. There are about 550 such health centers and they provide vitally needed access for medically underserved populations.

Concerns have been expressed to the committee regarding the precarious nature of the current authority for Medicare payments. Various specific concerns have been raised, as well. Among these concerns are: the ineligibility of community centers that are comparable to those receiving Medicare payments but are not receiving PHS grants under the two sections noted above; constraints on the range of covered benefits; inadequate reimbursement; and potential liability under the anti-kickback provisions of the Medicare statute for waiving deductibles and coinsurance for indigent patients. (Under the terms of their grants from PHS, these centers must charge patients on a sliding scale, based on the patients' ability to pay.)

The committee bill would provide statutory authority for Medicare payments to these health centers. The bill would essentially treat these centers, for coverage and reimbursement matters, in the same manner that rural health clinics are treated under the current statute. In particular, it would extend eligibility to additional centers, would expand covered services, waive the Medicare Part B deductible, and protect the centers from violations of the anti-kickback provision.

Sec. 4015—Physical and Occupational Therapy Services

Outpatient physical therapy and occupational therapy services are reimbursed under Medicare in a variety of settings and by a variety of methods. Among these, they are covered when furnished by an independently practicing therapist (i.e., services that are neither part of the services of an organization or agency nor furnished under arrangements with an organization or agency) in the therapist's office or in the patient's home. In this situation, the services are reimbursed on a charge basis, but there is a statutory maximum of $500 per year on the amount Medicare will recognize. (Medicare pays 80 percent of the recognized amount.) This amount has remained unchanged for many years and there is a growing concern that it creates a barrier to appropriate care.

The committee bill would increase the upper limit for these services to $750 per year. It would also request the Comptroller General to undertake a comprehensive study of how physical therapy and occupational therapy services are covered and reimbursed under Medicare. The committee is interested in a better understanding of how such services are furnished in various settings and under various conditions, the effects which Medicare requirements have on the availability and quality of such services, and the appropriateness of the reimbursement rules. The study would be due January 15, 1991.

Sec. 4016—Study of Reimbursement for Ambulance Services

Ambulance services are currently covered under Part B of Medicare and reimbursed on a charge basis. Reimbursement has been restrained by the Medicare economic index, as well as being subjected to the freezes imposed on Part B charges under previous budget reconciliation acts and the "inflation-indexed charge" restraint promulgated by the Health Care Financing Administration in 1986. Meanwhile, many ambulance providers have been subject to increased regulatory requirements, from State and local govern-

ments, regarding the scope and quality of the services they must provide. As a consequence, there is growing concern that the level of Medicare payments is inadequate to assure reasonable access to appropriate ambulance services.

The committee recognized these concerns, but concluded that it did not have sufficient information and analysis to undertake a reform of Medicare payments at this time. The committee bill, therefore, includes a study to be undertaken or arranged by the Secretary of HHS of the appropriateness of Medicare payment rates. The committee is interested in a comprehensive review of the various types of ambulance services and the conditions under which they are furnished, as well as an analysis of the effects which the current payment rules have on the availability and quality of services. The study results, and any recommendations from the Secretary for policy changes, would be due one year after enactment.

The committee is advised that the Health Care Financing Administration has been reviewing the coverage and reimbursement of air ambulance services, with a view towards potential changes in the current policies governing these services. While the committee does not have a view at this time on the merits of these issues and is interested in having them included in the study, the committee does not intend for HCFA to withhold policy changes which it might otherwise make, in order to await the outcome of this study.

Sec. 4017—Physician Payment Review Commission Study of Assistants at Surgery

Medicare currently reimburses under Part B for the services of a surgeon or a physician assistant, acting as an assistant at surgery. The former are reimbursed on a the basis of reasonable charges and the latter on the basis of special charge rules enacted in the Omnibus Budget Reconciliation Act of 1986. Other health care practitioners, including residents and registered nurses with special training for this purpose, perform these services.

The committee is interested in a comprehensive review of the appropriateness of the use of assistants at surgery, including the appropriateness of current Medicare policies on coverage and reimbursement. The Congress had previously asked the Physician Payment Review Commission to study the issue of what surgical procedures should require prior approval of the assistant at surgery, as a condition for Medicare reimbursement. The committee bill would expand the previous request of PPRC to include the broader study described above.

Sec. 4018—Study of Reimbursement for Blood Clotting Factor for Hemophilia Patients

Of the Nation's 20,000 people with hemophilia, 6.5 percent—approximately 1,300—are Medicare beneficiaries and most of these are on Medicare because of disability. Most hemophiliacs are dependent on clotting factor which makes their blood clot normally and prevents bleeding. Uncontrolled bleeding into joints and muscles causes crippling. Some hemophiliacs face life-threatening hemorrhages. Advances in management or acute bleeding episodes have brought a remarkable change in the lifestyle of persons with

hemophilia, significantly reducing morbidity, disability, days lost from work or school, unemployment and patient costs.

In recent years, partly in response to the spread of Acquired Immune Deficiency Syndrome, the blood products industry has developed virally-safe, highly purified clotting factor concentrates through the use of monoclonal antibodies. Many physicians treating hemophiliacs prefer these products over heat-treated products out of a belief that they have a reduced risk of transmitted viruses or contamination with extraneous blood proteins and a better record of efficacy.

However, the cost of these products has in some cases has at least doubled over the past 5 years. According to Glen F. Pierce, et al, in a June 16, 1989 *Journal of the American Medical Association* article, average treatment costs have escalated from $10,000 to more that $60,000 per year. The reasons for the increase in price are not clear to the committee at this time.

The committee is concerned that Medicare reimbursement rates for clotting factor have not kept pace with these medical and technological developments and is directing the Department to conduct a study, within 6 months of enactment, to review the current methodology for reimbursing for blood clotting factor under part B of Medicare and to evaluate the effect of current reimbursement rates on the accessibility and affordability of clotting factor to beneficiaries. The committee expects the Department's report to include recommendations. The committee recognizes that definitive human studies to demonstrate unequivocally the superiority of the newer clotting factor concentrates would be beyond the time frame of this study. The committee expects the Department to look to the best judgment of the medical profession and the basic science literature on viral and immune aspects of blood products in making its recommendations.

Subpart 3—Changes in Coverage and Miscellaneous

Sec. 4021—Mental Health Services

Psychotherapy and other treatments for mental illness and disorders are covered under Part B, subject to various conditions that can be a restraint on access. Services furnished by psychologists are currently covered only in community mental health centers. In addition, the patient is responsible for 50 percent coinsurance, instead of the standard 20 percent, and the maximum amount of Medicare reimbursement is $1,100 per year.

The committee bill would expand access to mental health benefits through several measures. It would eliminate the $1,100 annual limit, while retaining the 50 percent coinsurance. It would also cover the services of clinical psychologists and clinical social workers, to the extent such services would have been covered if furnished by a physician and if the services are ones which the psychologist or social worker is legally authorized to perform under State law.

The committee was concerned that a patient receiving mental health services might have physiological or medical problems, or be suffering from drug reactions or interactions, that are contributing to or causing his or her mental illness or disorder. This concern is

particularly warranted in the case of elderly patients, who often have multiple health problems and frequently are taking one or more prescription drugs. To make sure that such problems are detected, the bill would also require the psychologist or social worker furnishing mental health services to take appropriate measures to inform the patient about the desirability of seeing his primary care physician and to notify that physician of the care being furnished to the patient.

Sec. 4022—Nurse Practitioner Services

In the Omnibus Budget Reconciliation Act of 1986, the Congress authorized coverage and reimbursement for the services of physician assistants. Previously, such services had only been covered when furnished "incident to" a physician service. The 1986 provision, which was initiated by this committee, covered the services of a physician assistant when furnished in a hospital or nursing home or as an assistant at surgery. An amendment in 1987 added services furnished in a physician's office located in a rural health manpower shortage area. The 1986 provision also included a special payment formula and several other conditions on coverage and payment. The principal objective of this provision was to increase the delivery of appropriate services to residents of nursing homes. A Medicare demonstration program was indicating that furnishing physician assistant services on a regular basis to nursing home residents improved the quality of care and greatly reduced the need for hospital services.

Nurse practitioners perform many of the same services as physician assistants and do so in a generally comparable manner. They were also part of the Medicare nursing home demonstration project noted above. The committee bill would add nurse practitioners to the provision authorizing payments for physician assistants. It would generally apply the existing conditions and requirements to nurse practitioners, except that nurse practitioners would be required to work "in collaboration" with a physician (as defined in the statute), rather that acting "under the supervision" of a physician.

The committee bill also contains another provision designed to assure proper utilization of these services by nursing home residents. It would require the Secretary to instruct the Medicare carriers to develop utilization review mechanisms which permit payments, on a routine basis, for up to one-and-a-half visits per month per resident by a members of a team consisting of a physician and a physician assistant or nurse practitioner. It is the committee's understanding that, to be practical at this time, this review would have to be carried out on a patient-by-patient basis, although it would clearly have to be done by averaging the number of visits for a particular patient over several months. Moreover, the review is not intended to preclude medically necessary visits to a patient, but rather to act as a screen to monitor routine visits. The bill also contains a provision requiring the Secretary to conduct at least one demonstration project to determine whether this screening provision can be implemented by averaging the number of visits for a given month over all of the patients being furnished services by the team.

Sec. 4023—Coverage of Screening Pap Smears

Medicare generally does not cover screening or preventive services. Exceptions to this include flu vaccinations, pneumococcal vaccinations, hepatitis B vaccinations, and mammography screenings. According to the recently published report of the U.S. Preventive Services Task Force (Guide to Clinical Preventive Services, 1989) pap smears, used to detect cervical cancer, are another important screening service.

The committee bill would authorize payments for pap smears, including a physician's interpretation of the results, in accordance with frequency guidelines recommended by the Task Force. As a general rule, the exam would be reimbursed once every 3 years, but could be furnished more frequently in accordance with factors identified by the Secretary which indicate the patient is at high risk. The committee expects the Secretary to consult the Task Force report when implementing this provision.

Sec. 4024—Rural Health Clinic Services

Rural health clinics are reimbursed under Medicare in accordance with extensive conditions and requirements. When these provisions were enacted in 1977, the Congress anticipated there would be a large number of clinics established, but this has not proven to be the case. The committee report includes several provisions designed to promote the development of rural health clinics and improve access to their services.

First, it would change the current regulatory requirement that clinics have a physician assistant or nurse practitioner available to furnish services at least 60 percent of the time. It would change the rule to 50 percent and would allow the clinic to count the time of a nurse mid-wife.

Second, the bill would include coverage of clinical social workers among those who can furnish services at a rural health clinic.

Third, the bill would expand the number of areas which are eligible to have a qualified rural health clinic. Under current law, the area must be rural and must have been designated by the Secretary of HHS either under section 1302(7) of the Public Health Service Act as having a shortage of personal health services or under section 332(a)(1)(A) of that Act as being a health manpower shortage area. The committee bill would allow governors, with the approval of the Secretary, to designate additional rural areas as having a shortage of personal health services for purposes of being qualifying under this provision. It would also cite additional sections of the Public Health Service Act which, if a rural area has been designated by the Secretary for purposes of that Act, would serve to qualify the area under this provision.

Fourth, the bill requires the Secretary, in consultation with the Office of Rural Health Policy, to disseminate information on how to qualify to become a rural health clinic to appropriate agencies within 60 days of the enactment of this provision.

Fifth, the bill permits the Avalon Municipal Hospital on Santa Catalina Island to qualify as a rural health clinic. Avalon is the sole hospital and outpatient provider for the island's residents and tourists. Under the Rural Health Clinic Act, a rural health clinic

must utilize the services of a physician assistant or nurse practitioner. The population served by the hospital's outpatient clinic is so small that the hospital can not employ both a physician and a nurse practitioner or physician assistant. The committee bill would waive the requirement for a nurse practitioner or physician assistant so that the hospital could be certified as a rural health clinic. The hospital would have to meet all other requirements of the Act.

Sec. 4025—Limitations on Charges for Medicare Beneficiaries Eligible for Medicaid Benefits

Approximately 10 percent of Medicare beneficiaries are also eligible for full Medicaid benefits under the eligibility criteria established in each State. These are commonly referred to as "dual eligibles". In addition, a significant number of Medicare beneficiaries is entitled to have Medicaid pay their Medicare premiums and cost-sharing, because they meet income and resource standards established by the Medicare Catastrophic Coverage Act of 1988. These are referred to in the statute as "qualified Medicare beneficiaries".

Although the current statute does not explicitly require that physicians accept assignment for services furnished to dual eligibles, the requirements of the Medicaid program have had that result as a practical matter. Since physicians are precluded from billing patients under Medicaid, they must accept assignment in order to obtain any reimbursement from Medicaid. The Medicaid fiscal agents typically have arrangements with the Medicaid program so that the physician can submit a single claim to the Medicare program; the Medicare carrier, after processing the claim, will transmit it to the Medicaid administrator for further processing. The Medicaid programs typically pay the Medicare coinsurance only to the extent that their payment, plus the Medicare payment, does not exceed what the Medicaid program would pay for the service in question.

The current statute does not require that physicians take assignment for qualified Medicare beneficiaries. However, because these beneficiaries are not actually determined to be eligible for Medicaid under the State's eligibility criteria, they are not dual eligibles. Consequently, the Medicaid rules that result in assignment being accepted for all dual eligibles are not applicable to qualified Medicare beneficiaries. Thus, physicians are able to bill these patients directly and to charge amounts in excess of what Medicare determines to be reasonable and what Medicaid will reimburse. This appears to create an anomaly and defeats the Congressional purpose of protecting qualified Medicare beneficiaries from high out-of-pocket expenses for health care.

The committee bill would amend current law to require that physicians take assignment under Medicare for all services furnished to dual eligibles and qualified Medicare beneficiaries (if such services are also covered under the Medicaid program in the State). Thus, it codifies the current practice with respect to dual eligibles and extends it to qualified Medicare beneficiaries. It does not change the current policy regarding the amount which a Medicaid program must reimburse on such claims. It would also apply existing sanctions against a physician who knowingly and willfully bills a patient directly in violation of this new rule.

Sec. 4026—Study by Physician Payment Review Commission

The Physician Payment Review Commission (PPRC) was created by the Consolidated Omnibus Budget Reconciliation Act of 1985, based on provisions which originated in this committee. Its purpose is to review and evaluate the methodology for reimbursing physician services under Medicare and related issues, and to make recommendations to the Congress on policy changes. The Congress has enlarged the responsibilities of the PPRC since its original enactment, both through formal amendments to the statute and through informal requests. The PPRC has issued three annual reports, the most recent of which presents thoughtful recommendations for comprehensive reform of the Medicare payment system. These recommendations form the basis for the committee's payment reform proposal set forth in section 4001. The PPRC will continue to evaluate and monitor this reform and make recommendations to the Congress on further revisions. Section 4001 of the committee bill extends the PPRC's continuing responsibilities in this regard.

The committee is also interested in having the PPRC do a similar analysis of payments for physician services under Medicaid. Consequently, the bill would charge the PPRC with reviewing the adequacy and appropriateness of payments for physician services under State Medicaid plans.

The committee is particularly concerned that low Medicaid payment levels may be discouraging physicians from participating in Medicaid, although the committee recognizes that payment levels are only one determinant of of physician participation. A State-by-State comparison of Medicaid and Medicare payments for 1986 shows that, on average, Medicaid payments were 67 percent of the Medicare allowable charge for a brief follow-up office visit and 61 percent of the Medicare allowable charge for an appendectomy. In some States, the Medicaid rates were less than 40 percent of the Medicare rates. (see *Medicaid Source Book* (1988), Appendix G.) The committee anticipates that the PPRC will develop recommendations to the Congress with respect to changes in Medicaid payment policy that would improve beneficiary access to physician services of high quality, taking into account the circumstances unique to each of the three major beneficiary populations serviced by Medicaid (mothers and children, the elderly, and the disabled).

PART B—PROVISIONS RELATING TO PARTS A AND B OF MEDICARE

Sec. 4041—Health Maintenance Organizations and Competitive Medical Plans

Temporary Waiver for Watts Health Foundation. Section 9312(c) of the Omnibus Budget Reconciliation Act of 1986 provided for a temporary waiver of the "50/50 rule" in section 1876 of the Social Security Act (which requires that no more than 50 percent of an MHOS enrollees be Medicare and Medicaid beneficiaries) for the federally qualified HMO operated by the Watts Health Foundation. The committee bill would extend the waiver for 4 additional years, to January 1, 1994, with the requirement for an annual review by the Secretary of the plan's compliance with the quality assurance requirements of section 1876. Because the Foundation's HMO will

not be in compliance with the rule by January 1, 1990, an extension is essential if the HMO is to continue its section 1876 contract with Medicare.

The "50/50 rule" requires an HMO to attract at least one-half of its enrollees through contracts with employers in the service area or through other means of enrolling individuals who are not eligible for either Medicare or Medicaid. The purpose of the rule is to assure Medicare and Medicaid beneficiaries that their HMO will provide quality care and serve the entire community well. The committee believes the Watts Health Foundation has a long history of such service to the Watts community and surrounding areas. As an additional assurance of continued high quality of care during the waiver, the Secretary would conduct an annual review of the plan's compliance with the quality assurance requirements of section 1876. In the absence of this provision, such a review would normally be conducted every 2 years.

Limit on Charges for Emergency Services and Out-of-Area Coverage. Section 1842(h) of the Social Security Act provides for limits on the charges that physicians can bill for services furnished to Medicare beneficiaries. Physicians who have signed a participation agreement must accept the Medicare reasonable charge as payment in full and physicians who have not signed such an agreement cannot bill the patient more than the "maximum allowable actual charge" ("MAAC"), as determined under the statute.

In the circumstance where a physician is providing care to a Medicare beneficiary enrolled with an HMO or CMP and has no contract with the plan, these Medicare limits do not currently apply. The physician, whether he has signed a participation agreement or not, can charge any amount to the plan, since the plan has no protection against unreasonable charges.

HMO's and CMP's are required to provide all medically necessary services, including emergency and out-of-area services. While these plans have contracts with physicians to provide care to their enrollees, emergency care and medically necessary physician care provided outside the plan's service area (when a Medicare enrollee is traveling, for example) are often provided by physicians who do not have contracts with the plans. The committee's amendment would prohibit non-contract physicians from billing more than they could bill a Medicare patient under the limits established in accordance with section 1842. Participating physicians would have to accept the amount of the Medicare reasonable charge as payment in full from the HMO. Non-participating physicians could not charge the HMO more than their individual MAAC amounts prescribed under section 1842.

Disclosure of AAPCC Assumptions. The committee bill would require the Secretary to give HMO's advance notice of any changes in the methodology and assumptions used in the calculation of the payment rates for HMO's and CMP's under section 1876. Notice would be required 45 days prior to the announcement of payment rates for the following year.

Changes in methodology and assumptions can have a major impact on payment rates. The committee believes plans should have an opportunity to comment to the Secretary before any such changes take effect.

Incentive Payment Plans. The Omnibus Budget Reconciliation Act of 1986 included a provision which was designed to prohibit financial incentives between physicians and HMO's that might have an adverse impact on the quality of care being furnished. This provision was to take effect on April 1, 1990. The committee bill would repeal the provision.

Since this provision was enacted, there have been several studies on the subject. None has produced any evidence that HMO physician incentive plans have resulted in Medicare beneficiaries being denied medically necessary services. In the absence of such evidence, the committee believes there is no basis for deciding which particular incentive arrangements should be prohibited. Under these circumstances, it would be unwise to legislate any prohibitions.

Increase to 100 Percent of AAPCC. Under current law, payment rates for HMO's and CMP's are equal to 95 percent of the AAPCC. The committee's bill would increase the rate to 100 percent.

In the last 2 years, over 60 HMO's have dropped out of the Medicare section 1876 risk contract program, leaving approximately 130 risk contracts with HMO's. Many have cited inadequate payment rates as the reason for terminating their contracts. Because it is advantageous to Medicare beneficiaries to have the choice of getting health care through the fee for service system or through HMO's, the committee believes steps should be taken to encourage HMO's to continue in the risk program. The committee would also expect the Secretary to pay HMO's participating in demonstration projects at 100 percent of the AAPCC (unless the percentage amount was itself an issue being evaluated under the demonstration).

Sec. 4042—Peer Review Organizations

Practitioner right to reconsideration of PRO determination prior to notice to beneficiary. Under section 1154(a) of the Social Security Act, peer review organizations ("PRO's") are required to review services to determine whether they are medically necessary, whether their quality meets professionally recognized standards of care, and whether they were furnished in the appropriate setting. The section authorizes the PRO's to conclude that Medicare payments should be denied for services that do not satisfy these requirements. It also requires the PRO to notify both the provider of the service and the patient when it has made such a determination. Both the provider and the patient then have a right to have the PRO reconsider its determination that payment should be denied.

When these notice and reconsideration provisions were enacted, the PRO's did not have authority to deny payments for failure to meet professionally acceptable standards of quality. The provisions appeared to work reasonably well for denials based on the other two requirements. The authority of PRO's to deny payment for substandard care was added by the Consolidated Omnibus Budget Reconciliation Act of 1985, but no change was made in the statutory requirements for notice and reconsideration.

The Secretary issued a notice of proposed rulemaking, implementing the COBRA amendment, in January of this year. That proposed regulation retained the patient notice requirement as it

had previously been implemented. Secretary concluded that the statute gave him no discretion regarding when the notice of the denial was sent to the patient. Both the PRO's and the physician community, as well as some beneficiary groups, have expressed concern, however, about this arrangement. Many view it as likely to encourage unwarranted malpractice claims. Some also point out that it can be very confusing to patients if the PRO reverses its determination after the provider has received a reconsideration and the PRO then has to send a second notice to the patient reversing its earlier notice. This is not an infrequent occurrence.

The committee bill would address these concerns by amending section 1154 to require that, in the case of denials for substandard care, the provider or practitioner would receive its notice and have its right to reconsideration made available before the notice to the beneficiary. If the provider chose to have its reconsideration prior to the notice to the patient and the PRO reversed its determination, there would be no notice to the patient. If the provider chose to have its reconsideration prior to notice to the patient, and the PRO did not reverse its determination, the provider would not entitled to another reconsideration after the notice to the patient. The patient would retain the current right to a reconsideration following the notice.

The committee bill would also revise the language of the notice to the patient, in an attempt to make it clear that the denial was based on the PRO's judgment and did not necessarily represent conclusive evidence of malpractice. The notice would also state that the matter had been discussed with the patient's physician and provider, as an indication that the patient might want to pursue further discussions with either or both of them. The committee intends, however, that the PRO will be responsive to the patient should the patient inquire further of the PRO on the issues involved in the notice.

Clarification of willing and able test for physician sanctions. Under current law, PRO's are authorized to recommend to the Secretary that a physician be fined or excluded from the Medicare program for failure to provide care of acceptable quality, either in a substantial number of cases or in a gross and flagrant manner. The PRO's recommendations are reviewed by the HHS Inspector General, under authority delegated to him by the Secretary. If the sanction is approved by the Inspector General, the physician has the right to a formal hearing by an administrative law judge.

In addition to being found to have violated his obligation to provide quality care, the physician must be found to be unwilling to comply, or to lack the ability substantially to comply, with this obligation. This "willing and able" test is applied throughout the sanction process—by the PRO, the Inspector General and the administrative law judges. Several cases have arisen in which this test has been used by the physician unreasonably to undermine the sanction process. In these cases, the physician has demonstrated that he is not willing to cooperate with the PRO in pursing a course of remedial education or corrective action and has also refused to cooperate with the Inspector General. However, when it became clear that the evidence before the administrative law judge of his violation was too strong to rebut, he has declared to the

judge his willingness and ability to take corrective action. In this circumstance, some judges have dismissed the charges against the physician, despite having concluded that the physician had acted in gross and flagrant violation of his obligation, because they thought they had no discretion to impose a sanction on a physician who had now declared his willingness, albeit belatedly, to comply.

The PRO's have expressed concern that results such as these clearly undermine the integrity of the sanction process and discourage PRO's from initiating sanction cases, even when clearly warranted. Several years and considerable resources can be consumed in the process that turns out to be quite futile. The Administrative Conference of the United States recently reviewed this matter thoroughly and adopted a recommendation that the Congress delete or modify the willing and able test.

The committee bill would respond to these concerns and recommendations by clarifying the willing and able test. First, it would incorporate into the statute the current practice followed by nearly all PRO's of trying to achieve voluntary compliance with a plan of remedial action prior to pursing a recommendation for sanction. Second, it would make it clear that the administrative law judge, in making the final determination whether the physician is willing and able to comply with his obligations, should consider the physicians prior actions in cooperating with or defying the PRO. The judge would expected to review whether the remedial plan recommended by the PRO was appropriate and, if so, whether the physician acted responsibly in light of the weight of evidence against him. The judge could also consider other corrective action the physician took on his own initiative, in lieu of following the PRO recommendation.

Increase in population threshold for pre-exclusion hearing. The Omnibus Budget Reconciliation Act of 1987 amended the administrative process followed when a PRO recommends that a physician be excluded from the Medicare program for failure to fulfill his obligation under the Medicare statute to furnish care of acceptable quality. An exclusion would normally become effective upon the Inspector General's concurrence with the PRO recommendation and would remain in effect during the conclusion of the administrative appeal. The 1987 amendment provides that physicians furnishing services in a rural health manpower shortage area or in a county of less than 70,000 population may receive a prompt, preliminary hearing before an administrative law judge to determine whether their continuation in the program poses an unacceptable risk to patients. The purpose of the amendment was to avoid creating a problem of access to services in underserved areas.

Experience to date has not demonstrated any serious problems with this provision. The bill would increase the population threshold for areas to which this provision is applicable. The threshold would increase from 70,000 to 140,000.

Increase in civil monetary penalties. A physician who fails to meet his obligation under the Medicare statute to provide care of acceptable quality may be excluded from the program. As an alternative sanction, he may be fined in an administrative proceeding. Under current law, the fine may not exceed the actual or estimated cost of the medically improper or unnecessary services that

were furnished. In some cases, this may be a small amount, even though the actions of the physician were serious enough to warrant a sanction proceeding. The small amount of such fines acts as a disincentive to PRO's to recommend such sanctions. Therefore, the committee bill would increase the fine to $2,500.

Sec. 4043—Payments for End Stage Renal Disease Services

Under current law, Medicare reimburses for dialysis treatments furnished patients with end stage renal disease under either of two methods. One method is an all inclusive rate per treatment, known as the "composite rate" because it is based on a blend of the costs entailed in furnishing dialysis services in a treatment facility and the costs of furnishing them in the patient's home. The same rate is paid irrespective of the site of service.

The other method of payment, commonly referred to as "method II", is the standard reasonable charge method used for Medicare Part B services. Method II is offered as an alternative to the composite rate in order to allow the patient to make his or her own arrangements for supplies and equipment. By doing so, the patient is often able to save on coinsurance expenses.

Composite rate. The current composite rate has been in effect since October 1, 1986, when it was established under the terms of the Omnibus Budget Reconciliation Act of 1986. The Congress established the rate at that time in order to preclude HCFA from implementing a proposed substantial reduction. Under the terms of OBRA 1986, the rate was to remain in effect until October 1, 1988, at which time HCFA could revise it. It was the committee's understanding of this provision that HCFA would be required to obtain more current cost data and to satisfy the procedure for notice and public comment prior to making a change. In presenting its fiscal year 1990 budget proposals, the Administration, argued to the contrary, that it had authority to reinstate the 1986 proposed reductions. HCFA has also indicated that it has obtained more recent cost data that support a reduction in the current rate.

The committee does not have a basis at this time for determining what the composite rate should be. It notes that the Institute of Medicine, at the request of the Congress, is conducting a comprehensive review of the ESRD program that should be of assistance in resolving this issue. The study is due for completion next year.

Under these circumstances, the committee is concerned about HCFA's apparent intention to proceed with a reduction in the rate. Therefore, the committee bill would require that the current rate be maintained until October 1, 1989. At that time, HCFA would be authorized to change the rate. However, the bill would also require that the notice and comment requirements of the Medicare statute be followed before any change becomes effective. The committee also expects HCFA to base any proposed change on cost data that is less than 2 years old at the time of the proposed change.

Method II. The committee bill would also make a change in method II. As noted above, the purpose of this method is to allow patients to make their own arrangements, as a matter of convenience for themselves or to save out-of-pocket expenses. The committee has learned, however, that firms are taking advantage of method II to furnish dialysis equipment and supplies to patients

and to submit claims on a reasonable charge basis that exceed what payments would be under the composite rate. The committee bill would not repeal method II nor prohibit suppliers from arranging services on behalf of patients. However, it would preclude payments under method II from exceeding the composite rate.

Sec. 4044—Payments for Direct Medical Education

Under current law, hospitals receive payments under Medicare for a portion of their direct medical education costs under a formula that takes into account the number of full-time-equivalent (FTE) medical residents in the hospital's approved training programs. Residents who are in their initial residency period are counted as 1.0 FTE's, and those who are in more advanced training are counted as 0.5 FTE's.

The current direct medical education system pays the same, hospital-specific average amount per resident, regardless of the specialty for which a resident is training. This fails to promote the Congressional policy of fostering primary care training and greater access to primary care services. Moreover, primary care training programs are at a disadvantage, compared to other specialties, in trying to obtain other resources to support residency programs.

The physician payment reform set forth in section 4001 is expected to reduce the current imbalance in the financial incentives that favor specialty physician services over primary care physician services. The committee hopes that this will also have a beneficial influence on the similar imbalance between specialty training programs and primary care residency programs. This provision reflects the committee's resolve to take further, direct measures to adjust graduate medical education payments in order to promote the Congressional policy that favors primary care residency programs.

Under this provision, primary care residents would be counted as 1.25 FTE's, thus increasing payments to programs in proportion to their relative number of primary care residents. This weighting is based on the overwhelming proportion of graduates of such programs who actually practice as primary care physicians. Other residents in primary care specialties would be counted as 1.10 FTE's. This reflects the fact that such physicians, although generally going on to establish specialty practices, actually deliver a substantial amount of primary care as well. All other residents would continue to be counted in the same manner as under current law.

The primary care residents to be counted as 1.25 FTE's are those in general training programs. This would include all residents in approved Family Medicine programs, as well as residents in general internal medicine and general pediatrics. The committee notes that there is no formal approval mechanism for general internal medicine or general pediatrics training programs at this time, and has determined that the Secretary should identify such programs using the following criteria: 1) any program component or track that has ever had an application approved for a grant under section 784 of the Public Health Service Act, whether funded or not; 2) any program identified by the Society for General Internal Medicine or the Ambulatory Pediatric Association as a general program; or, 3) any other program that meets criteria established by the Sec-

retary, including: at least 20 percent of training experience devoted to providing continuing care to a defined panel of patients, not to include subspecialty clinics or emergency room rotations; well-defined biopsychosocial or behavioral curriculum taught in primary care settings; emphasis on teaching in primary care settings, particularly community-based ones; and, a defined curriculum in health promotion, disease prevention, and social aspects of medicine. When a general program is a component or a track of a larger traditional program, only those residents actually in the general track will count as 1.25 FTE's, and the others are to count as 1.10 FTE's.

To keep this provision budget-neutral, a limitation is established on the amount that can be approved per resident in any program. Programs with hospital-specific average per-resident expenses above that level will be paid at the ceiling rather than the amount that would otherwise be calculated under current law. The limits are adjusted for the proportion of primary care residents, so as not to undermine the main objective of this provision. Thus, equally expensive programs are treated differently depending on their proportion of primary care trainees.

Sec. 4045—Distribution of Information on Recommended Preventive Health Practices

According to the U.S. Preventive Services Task Force, the most promising role for prevention in current medical practice may lie in changing the personal health behavior of patients before clinical disease develops. (See *Guide to Clinical Preventive Service,* 1989.) There is a growing body of evidence linking personal behavior to the leading causes of death in this country. Unfortunately, many elderly Americans lack information on how personal behavior might affect their health. Busy clinicians often lack the time to discuss or provide preventive care services to their patients. Many other elderly persons lack information because they do not regularly visit a physician until after they are enrolled in Medicare.

The committee bill seeks to promote greater awareness and compliance with preventive health measures among Medicare enrollees. This provision requires the Secretary of Health and Human Services to develop and distribute two documents. One is a personal medical history form, which will be given to all new Medicare beneficiaries when they enroll in the program. The second is a summary of preventive health care information. The summary will be made available to all new Medicare beneficiaries, and will be included in future mailings made to all Medicare beneficiaries. The medical history form would be one full-sized page. The committee expects the summary to be brief, so that it is convenient for mailing and use by enrollees, but should be sufficiently long to adequately convey the full range of useful information. Both documents are to be developed by the Secretary in consultation with national physician organizations (such as the American Association of Family Practitioners), consumer groups, and other health-related organizations.

The medical history form should provide space for the individual to enter information on personal and family medical history, weight and blood pressure, and other relevant basic medical infor-

mation. The committee believes that, for the medical history form to be useful, it should also do the following:

(1) Inform individuals of the importance of preventive care in reducing the incidence of clinical problems and the importance of their providing their physician with adequate background information for prescribing appropriate preventive treatments.
(2) Encourage individuals to fill out the form, using community health facilities, when available, to get information such as blood pressure reading or visual or hearing tests.
(3) Encourage individuals to share the information on the form with their physician on their next regular visit, to discuss appropriate preventive health care measures.
(4) Encourage the physician to carefully review the information provided by the patient, discuss its implications with the patient, and make the form part of the patient's permanent file.

The summary of preventive health care information would provide basic information on preventive care practices, screening, tests, and immunizations recommended for elderly individuals. In developing the form, the Secretary should incorporate recommendations, as they pertain to persons over age 65, of an appropriate task force or similar group established by the Secretary, such as the U.S. Preventive Task Force.

The summary should indicate, where appropriate, which recommended procedures are not reimbursable under Medicare, so there will be no confusion on the part of the Medicare enrollees, who might otherwise infer that recommended procedures would be paid under the program.

The summary and form are to be developed by April 1, 1990, and distribution is to begin no later than October 1, 1990.

PART C—OTHER PROVISIONS RELATING TO MEDICARE AND HEALTH-RELATED PROGRAMS

Sec. 4061—Administrative law judges for health related cases

A variety of administrative appeal procedures utilizing administrative law judges are contained in the Medicare program, the Medicaid program, the Peer Review Program and the fraud and abuse provisions contained in title XI of the Social Security Act. Currently, most of these appeals are heard by administrative law judges from the Office of Hearings and Appeals in the Social Security Administration, although some of the sanction cases initiated by the Inspector General are now heard by judges who are part of the Department Appeals Board.

The committee, on two prior occasions—in its reports for the budget reconciliation provisions for 1985 and 1986—has urged the Secretary to appoint administrative law judges who would focus exclusively on health related cases. The subject matter of these cases is sufficiently different from the nature of other cases heard under the Social Security and disability programs, and the case load for health-related cases is sufficiently great, to warrant this specialization. The Secretary has not yet done so, in part because of disagree-

ments on where such judges should be located within the organizational structure of the Department.

The committee has concluded that this action will not take place unless the Secretary is directed to do so legislatively. The committee believes that health related cases will be resolved more satisfactorily if they are handled exclusively by a single set of judges and, therefore, places this requirement in the statute.

The committee does not instruct the Secretary as to where in the organizational structure of the Department such judges should be located. It is explicitly not requiring that they be placed under the supervision and control of the Administrator of HCFA. The Departmental Appeals Board would appear to be an appropriate location for these judges and the committee urges the Secretary to give serious consideration to that option. The Board is an independent office within the Department, established to review disputes between departmental agencies and their grantees, to adjudicate civil remedies cases, and to perform other review and mediation services assigned by the Secretary. It has developed a reputation for objectivity and competence.

The committee assumes that appropriate funds would be transferred from the Social Security Administration to whatever other unit of the Department takes over this responsibility.

Sec. 4062—Amendments Relating to the United States Bipartisan Commission on Comprehensive Health Care

This section of the committee's bill makes a number of small changes in the structure and operation of the U.S. Bipartisan Commission on Comprehensive Health Care. The purpose of the Commission, as established in the 1988 Medicare Catastrophic Coverage Act (Public Law 100-360), is to study and make recommendations to the Congress on both long-term care services for the elderly and comprehensive health care for all Americans.

Under this section, five modifications are made to the law which created the Commission. These include increasing the number of vice-chairmen of the Commission to four; providing franking privileges to the Commission; establishing printing procedures for the Commission's mandated reports; and changing the date by which the Commission's reports must be concurrently submitted to the Congress to November 9, 1989. The final modification provides that the Bipartisan Commission is also be known as the "Claude Pepper Commission" or the "Pepper Commission", in tribute to the late Congressman Claude Pepper, the Commission's first chairman.

The committee notes that all of the statutory changes included within this section of the bill were discussed and unanimously agreed to by the members of the Commission during its meetings held earlier this year. Thus, the purpose of this section is to implement these decisions and recommendations of the full Commission membership.

Sec. 4063—Office of Rural Health Policy

Under current law, there is a statutorily created Office of Rural Health Policy. It is located in the Health Resource and Services Administration in the Public Health Service. It is responsible for making sure health issues of particular concern to rural areas are

given appropriate attention within the Department and that the interests of rural areas are adequately represented in the discussion and resolution of health issues.

The committee bill would upgrade the Office by placing it in the office of the Under Secretary and making the head of the Office a Deputy Under Secretary. This is intended to give the Office more influence on a broader range of issues. The bill would also expand the responsibilities of the Office by explicitly listing a broad range of subject areas within its purview.

Sec. 4064—Expressing the Sense of the Congress respecting Making Receipt of Medicare Benefits Added, and Premiums Imposed, by the Medicare Catastrophic Coverage Act of 1988 Voluntary

Members of the committee have received a substantial volume of complaints about certain aspects of the Medicare Catastrophic Coverage Act enacted last year, which added new benefits and premiums to the Medicare program and made improvements in the Medicaid program. The committee members discussed the concerns being expressed, as well as ways in which the committee might be responsive to them.

A large percentage of these complaints concern the supplemental premium, which is imposed on all persons who are eligible for coverage under Part A (and have sufficient income to become liable for such premium) irrespective of whether they have alternative health insurance coverage or whether they desire coverage of the new benefits. It is not within the jurisdiction of the committee to make changes in the supplemental premium rates established in the current statute, so the committee was not well situated to make comprehensive revisions in the Act. Rather than passing inadequate and unsatisfactory measures, the committee adopted a resolution that it is the sense of the Congress that legislation should be passed this session which would make the new CATASTROPHIC benefits optional and would impose the supplemental premium only on those who chose such coverage.

Sec. 4065—Expressing the Sense of the House of Representatives Respecting Review of, and Hearings on, the Medicare Catastrophic Coverage Act of 1988

As noted in the discussion regarding section 4064 above, there is strong interest in the committee in trying to be responsive to the concerns and criticisms being expressed about the Medicare Catastrophic Coverage Act of 1988. Prior to acting on the resolution set forth in section 4064, the committee adopted a resolution setting forth the sense of the House that the two committees having jurisdiction with respect to the Act—this committee and the Committee on Ways and Means—should hold hearings and review the Act.

Subtitle B—Health Care Research and Policy

Part A—Agency for Health Care Research and Policy

Sec. 4101—Establishment of Agency

This section amends the Public Health Service Act by creating a new Title IX to establish within the Public Health Service a new agency, the Agency for Health Care Research and Policy.

Under current law, a broad range of responsibilities for health services research, evaluation, and demonstration projects is assigned to the National Center for Health Services Research and Health Care Technology Assessment (NCHSR), located within the Office of the Assistant Secretary for Health. Most of this work is supported by appropriations from general revenues for conducting health services research. In addition, Section 1875 of the Social Security Act provides for the transfer of funds from the Medicare Part A and Part B trust funds to NCHSR to conduct research on the outcomes of medical care. The committee believes that carrying out these broad mandates requires a far greater Federal effort than has been conducted to date by NCHSR. Full agency status should help assure the stature and resources needed for the task.

The purpose of the new Agency for Health Care Research and Policy is to enhance the quality, appropriateness, and effectiveness of health care services, and to improve access to such services. The Agency is to do this through the establishment of a broad base of scientific research and through the promotion of improvements in clinical practice and in the organization, financing, and delivery of health care services. The agency will conduct and support research, demonstration projects, evaluations, training, and the dissemination of information to carry out its purpose.

Research on the outcomes of health care services and procedures is an important part of the Agency's mandate. Such research, however, must be carried out in accordance with provisions of the Social Security Act that are described below.

Under current law, a specific percentage of funds are set aside for intramural research by the National Center for Health Services Research. The committee has decided not to constrain the authority of the Administrator with specific set-asides at this time. Nevertheless, the committee expects the Agency to continue a vigorous intramural research program, just as the National Institutes of Health does.

The committee has identified certain high-priority areas for the Agency. These include medical liability and clinical practice, specifically primary care and practice-based research.

The small amount of good research, evaluations and demonstration projects on medical liability that exist show that this area has received far too little attention. Our medical liability system is intended to be a last-ditch quality control measure that constrains negligent behavior by physicians. All too often, however, it affects the character of the physician-patient relationship by introducing a litigious atmosphere. The medical liability situation is also cited as a factor in stimulating defensive medicine and increasing health care costs. In addition, the Subcommittee on Health and the Environment has heard repeated testimony that medical liability prob-

lems have seriously compromised the willingness of obstetricians and family physicians to provide pregnancy care, particularly in rural areas. Medical liability difficulties have even shut down obstetrical care at Community Health Centers.

The committee believes that medical liability is a ripe area for innovative research, evaluations and demonstration projects. This topic is of far greater importance than the current level of effort would suggest. The committee expects such work to be a significant component of the Agency's activities.

Research on primary care, particularly research based in clinical practice, is another area of health care that has not received adequate attention. Fostering practice-based research requires a series of activities. Individuals already engaged in, or just entering, active clinical work must be adequately trained in research methodologies. Collaborative networks must be established to have a representative base for research. Research agendas should be developed. All of these activities are necessary for the Agency to have an appropriate program in primary care and office-based research.

The committee also expects the Agency's activities to include research on methods of improving communications between physicians and patients and of encouraging patient compliance with treatment and prevention regimens.

The Agency's program of conducting and supporting research is to be complemented by a substantial program of dissemination and related activities. Health care research and policy must reach a wider audience and do so on a more timely basis than permitted just by publication in scientific journals. Of equal importance, the Agency must make data tapes developed by the intramural program available as promptly as possible for analysis by researchers in the field. Such tapes are important public resources that should not be restricted to the intramural program or retained until they are outdated.

The bill makes certain changes with respect to technology assessment. Under Section 309 of the Public Health Service Act, the Secretary has made grants to the National Academy of Sciences to establish a council on health care technology. While recognizing the difficulties involved in setting up such a new entity, the committee believes that the approach under current law has not brought about the kind or level of activity that it had anticipated, particularly with respect to the review of existing health care technologies, and the collection and analysis of data concerning specific health care technologies. The committee has decided to phase out the Council over the next year and to place responsibility for this set of activities within the new Agency. The Agency, as under current law, also will make recommendations to HCFA on reimbursement of specific technologies.

Training opportunities in health care research and policy are essential for the field to expand to the level warranted by the importance of such work. Accordingly, the Agency is given specific authority to conduct training activities. In addition, the existing authority of NCHSR to administer ½ of 1 percent of National Research Service Awards is transferred to the new Agency. Individual and institutional awards will allow training of physicians, dentists,

social scientists, and other professionals in health care research and policy.

The committee notes that dramatic changes have occurred in the organization, financing, and delivery of dental care. So, too, have changes taken place in population demographics and dental disease rates. Understanding these changes and their effect on health care is vital to maintaining high quality care while improving the cost-effectiveness and accessibility of our Nation's oral health care delivery system. Because of the importance of dental health care research and policy, the committee expects that the training program of the Agency, including individual and institutional NRSA awards, will include an appropriate representation of dental researchers.

This section also establishes a Forum for Quality and Effectiveness in Health Care. The purpose of the Forum is to convene nongovernmental panels of experts, physicians, and consumers, and to contract with private nonprofit organizations, to develop and update clinically relevant practice guidelines and standards of quality, performance measures, and medical review criteria. After consultation with appropriate experts, the Forum will establish priorities and strategies for the development of the guidelines, standards, measures and criteria. It will also establish criteria and standards to be used by panels and contractors in such development.

The Forum structure is designed to accommodate and balance the growing interest of a broad range of parties and organizations in the development of guidelines, which interests sometimes have disparate perspectives. There is a broad consensus that the Federal Government should not develop these guidelines. The Forum satisfies this concern, since no one in the Forum or the Department of HHS would have any authority to review, modify, approve or disapprove the guidelines developed by panels or contractors. On the other hand, the committee believes it is essential that there be a focal point for this activity and that a Federal official be held accountable to make sure the activity is carried out properly.

The Forum can either convene panels or contract with appropriate groups that satisfy criteria established for this purpose. The committee expects there to be a balance of both types of activity. At the outset, the Forum may need to rely more heavily on contracting, in order to get a program underway promptly, with emphasis gradually shifting more heavily toward the use of panels. The committee bill also makes it clear that the Forum can put its imprimatur on guidelines developed by other appropriate groups.

To be credible, guidelines developed under this provision must be formulated by objective, representative people of recognized authority and expertise. The Forum would be required to consult widely before selecting these panels of experts.

The panels and contractors would be expected to survey the available research literature and patient care data and to select the best information in developing guidelines. However, expert judgment would also be required and the Forum should not become stymied in its efforts because the research is less than perfect. Similarly, the guidelines are intended to help physicians provide services in a more effective and appropriate manner. The Forum

should not consider itself compelled to come up with the single best approach to a patient problem or condition, if consensus cannot be reached on a single approach but there is agreement that care can be improved through the use of a set of guidelines. In such circumstances, the Forum can provide for alternative approaches, with appropriate commentary on which ones appear to be preferable under various circumstances.

The Forum is to assist in the dissemination of guidelines, standards, measures, and criteria. Dissemination would primarily be the responsibility of organizations representing providers or consumers of health care, peer review organizations, and other entities. The Forum will evaluate the effect of its products on clinical practice and provide feedback to the Agency on research needed to carry out its purpose.

The committee notes that the term "physician" used in this subtitle is intended to encompass a range of health care practitioners, including, in many cases, all those practitioners who are qualified to participate in the Medicare program. It is especially important that the process of developing guidelines under the Forum include the practitioners for whom the particular guidelines will be pertinent.

PART B—OUTCOMES OF HEALTH CARE SERVICES AND PROCEDURES

Sec. 4111—Establishment of Program of Research

This section amends the Social Security Act to establish a program of Research on Outcomes of Health Care Services and Procedures. Under current law, section 1875 of the Social Security Act provides for the transfer of $10 million from the Medicare trust funds to the National Center for Health Services Research for outcomes studies. The committee bill establishes a similar, but greatly expanded, program. Because the National Center for Health Services Research is eliminated and replaced by the new Agency for Health Care Research and Policy, the bill requires the Secretary to conduct and support such research through that new Agency.

Although the research program is to be conducted through the Agency, these provisions in the Social Security Act are the ones that establish the processes for setting priorities for outcomes research and for improving such research.

The program allows the Administrator to conduct preliminary assessments to select the services and procedures that are to be given highest priority in outcomes research. In particular, it would be appropriate for the outcomes research to focus on services and procedures that vary in utilization rates, have uncertain effects, or are inappropriately used. For that reason, the Administrator could conduct preliminary assessments to identify the services and procedures that demonstrate those characteristics.

The bill identifies four factors to be considered when the Administrator is establishing priorities for outcomes research. While these factors are always to be considered, it is not the committee's intent that all four factors necessarily be fully satisfied before an area is identified as appropriate for research. For example, research on the outcomes of primary care might well be considered a high priority, even though the data necessary for such evaluations

are not readily available or readily developed, if the other three factors weigh heavily.

To carry out the program of outcomes research, the bill authorizes appropriations of $8.3 million in fiscal year 1990, $12.5 million in fiscal year 1991, and $16.7 million in fiscal year 1992, and in addition authorizes transfers of $16.7 million in fiscal year 1990, $25 million in fiscal year 1991, and $33.3 million in fiscal year 1992 from the Federal Supplementary Medical Insurance (Medicare Part B) Trust Fund.

PART C—ADDITIONAL AUTHORITIES AND DUTIES WITH RESPECT TO AGENCY FOR HEALTH CARE RESEARCH AND POLICY

Sec. 4121—Advisory Council, Peer Review, Administrative Authorities, and other General Provisions

This section adds further provisions to the new Title IX of the Public Health Service Act created by section 4101.

The bill establishes a public-private council known as the National Advisory Council for Health Care Research, Evaluation, and Policy to advise the Agency. The Council is to advise the Secretary and the Administrator with respect to the carrying out the broad mandate of the Agency. Among its activities, the Council is to make recommendations regarding priorities for a national agenda for research, for the program of clinical practice guidelines, and for the development of technology assessments.

The Council is to consist of both Federal and private individuals. The majority are to be distinguished researchers in related fields of health policy and practice. These researchers can and should include physicians, particularly physicians involved in primary care and clinical practice research.

Other members of the Council would include distinguished medical practitioners, other distinguished professionals, and consumer representatives. Among the distinguished professionals are to be persons from the fields of business, law, ethics, economics, and public policy. Business representatives would appropriately include individuals from, for example, the health insurance industry, and the manufacturers of medical care products.

As under current law, the bill requires scientific peer review of all grants and contracts. The committee notes that it has received numerous examples of areas in which the current peer review system could be improved. In particular, a number of researchers have commented that the peer review process does not assure that reviewers of particular proposals will actually be researchers with appropriate training and interests—i.e., peers. The committee expects the Agency to establish study sections with a composition and organization that will assure appropriate review by persons with experience and training directly relevant to the proposed research or other activities.

In addition, for proposals of less than $50,000, an exception is made to the general requirement of peer review. The Administrator is permitted to establish a separate, and less burdensome, review process for such proposals. One purpose of doing so is to remove barriers for new researchers entering the field. This process should encourage new and future researchers, including those

from institutions with future promise but limited track record, as well as those from clinical-practice situations rather than research-based institutions.

To carry out the activities other than research on the outcomes of heath care, the committee bill authorizes appropriations of $35 million for fiscal year 1990, $50 million for fiscal year 1991 and $70 million for fiscal year 1992, and sets aside 40 percent of departmental evaluation funds for use by the Agency (estimated at approximately $30 million for fiscal year 1990).

PART D—GENERAL PROVISIONS

Secs. 4131 through 4135

The committee bill also contains a variety of other provisions to implement the new agency authority and transfer functions and resources from existing agencies. It repeals the National Center for Health Services Research and Health Care Technology Assessment and the Council on Health Care Technology, but provides for a 1 year contract with the Institute of Medicine to complete current projects being undertaken by the Council and to facilitate a transition to the new Agency. It also makes other technical and conforming changes, including continuation of the National Center for Health Statistics.

Subtitle C—Medicaid

PART A—INFANT MORTALITY PROVISIONS

The United States ranks 19th among industrialized nations in infant mortality, behind Japan, Canada, Hong Kong, Singapore, and 14 other countries. About 40,000 American infants die each year before their first birthdays. A black infant in this country is twice as likely as a white child to die before the age of 1 year.

In August, 1988, the bipartisan National Commission to Prevent Infant Mortality issued a report, *Death Before Life: The Tragedy of Infant Mortality.* The Commission called for universal access to early maternity and pediatric care for all mothers and infants. One element of the Commission's action plan for assuring universal access was upgrading coverage under Medicaid, the Federal-State entitlement for the poor. Another element was improving the Title V Maternal and Child Health Block Grant program. As contemplated by the fiscal year 1990 Budget Resolution, the committee bill revises both the Medicaid and MCH programs to target Federal resources more effectively on low-income pregnant women and infants in order to improve birth outcomes.

Sec. 4201—Phased-in Mandatory Coverage of Pregnant Women and Infants up to 185 Percent of Poverty Level

(a) *Phased-in Mandatory Coverage.* Under current law, States are required to offer Medicaid coverage to pregnant women and infants up to age 1 with incomes below 75 percent of the Federal poverty level. Effective July 1, 1990, States must extend coverage to all pregnant women and infants with incomes below 100 percent of poverty. States have the option of extending Medicaid coverage to all pregnant women and infants with incomes up to 185 percent of

the poverty level. In each case, the coverage determination is based on income, not on whether the woman or infant is receiving cash assistance, or whether the family unit has one parent or two, or whether the principal earner is unemployed. States also have the option of applying a resource test in determining eligibility for these individuals. Coverage for pregnant women is limited to services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate the pregnancy. Coverage for infants includes all the services the State offers to an individual receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program.

Over the past few years, a number of States have made substantial progress in improving Medicaid coverage for pregnant women and infants. The National Governors' Association reports that, as of July, 1989, 44 States (including D.C.) extended coverage to all pregnant women and infants with incomes at or below 100 percent of the Federal poverty level; 14 States offered coverage to those with incomes at or below 185 percent of poverty; and an additional 6 States offered coverage to those with incomes above 100 and below 185 percent of poverty. (See Table 1). While these expansions are important, they are not, in the view of the committee, sufficient to assure financial access to prenatal care for all poor and near-poor women and infants in this country.

Table 1.—MEDICAID COVERAGE OF PREGNANT WOMEN, INFANTS AND CHILDREN, JULY 1989

	Pregnant women and infants percent poverty	Children under poverty coverage to age 2–5	5–8
Alabama	100		
Alaska	100	X	
Arizona	100		X
Arkansas	100		X
California	185		
Colorado	75		
Connecticut	185		
Delaware	100	X	
District of Columbia	100	X	
Florida	150		X
Georgia	150	X	
Hawaii	100		
Idaho	75		
Illinois	100		
Indiana	125	X	
Iowa	185		X
Kansas	150		X
Kentucky	125	X	
Louisiana	100		X
Maine	185		X
Maryland	185	X	
Massachusetts	185		X
Michigan	185	X	
Minnesota	185		X
Mississippi	185		X
Missouri	100	X	
Montana	100		
Nebraska	100	X	
Nevada	75		
New Hampshire	75		

Table 1.—MEDICAID COVERAGE OF PREGNANT WOMEN, INFANTS AND CHILDREN, JULY 1989—Continued

	Pregnant women and infants percent poverty	Children under poverty coverage to age 2–5	5–8
New Jersey	100	X	
New Mexico	100	X	
New York	[1] 185		
North Carolina	100	X	
North Dakota	75		
Ohio	100		
Oklahoma	100	X	
Oregon	85	X	
Pennsylvania	100	X	
Rhode Island	185	X	
South Carolina	[1]185	X	
South Dakota	100		
Tennessee	100		X
Texas	[1]130	X	
Utah	100	X	
Vermont	185	X	
Virginia	100		X
Washington	185		X
West Virginia	150		X
Wisconsin	82		
Wyoming	100		
Total	51	21	14

[1] Effective January 1, 1990, in New York; October 1, 1989, in South Carolina; September 1, 1989 in Texas.

Source: National Governors' Association.

In its August, 1988, report, the National Commission to Prevent Infant Mortality concluded that universal access to early maternity and infant care was an essential element of a national effort to reduce infant mortality. "The first step toward guaranteeing pregnant women and infants the care they need," the Commission found, "is assuring access to maternity and infant care. The primary responsibility for achieving this goal rests with the private sector and employers who help provide the vast majority of health care in this country. But the government must assure more responsibility for those who lack private insurance or are unable to pay." With respect to the government's responsibility, the Commission recommended that Medicaid be expanded to cover all pregnant women and infants with family incomes at or below 200 percent of the Federal poverty level. *Death Before Life: The Tragedy of Infant Mortality* at pp. 17–18.

The committee concurs. We as a Nation must invest in prenatal and maternity care services for poor and near-poor women and infants. It is obvious from data presented by the Commission and by other witnesses before the Subcommittee on Health and the Environment, that private insurance coverage of low-income women and children is limited and cannot realistically be expected to fill the coverage gap. A sensible response at this point is to require of the States what is now optional: extend Medicaid coverage of pregnant women and infants up to age 1 with incomes at or below 185 percent of the Federal poverty level ($18,611 for a family of 3 in 1989).

Under the committee bill, the mandate would be phased in over 4 years. As recommended by the Administration in its February 9, 1989, budget submission, *Building a Better America,* States would be required to extend Medicaid coverage to all those at or below 130 percent of the Federal poverty level effective April 1, 1990. As of July 1, 1992, this minimum income threshold would increase to 150 percent of the poverty level. Effective July 1, 1993, all States would be required to cover all pregnant women and infants with incomes below 185 percent of the poverty level. In determining income eligibility, medical expenses are not taken into account; unlike the "medically needy" option, pregnant women and infants with incomes above 185 percent of poverty cannot "spend down" into eligibility on the basis of high medical bills.

States that, as of enactment, already extend, or are scheduled to extend, coverage to pregnant women and infants with incomes above 130 percent of the poverty level must keep their eligibility thresholds at the higher of that level or the levels mandated under the committee bill. For example, a State which, as of July, 1989, has elected to cover pregnant women and infants with incomes below 185 percent of the poverty level would be required to continue to do so, even though other States that currently set their thresholds at 75 percent of poverty would have until July 1, 1993, to phase up to 185 percent. Of course, the current law option allowing States to extend coverage immediately to pregnant women and infants below 185 percent of poverty would remain in effect; it is the hope of the committee that all States will elect this option well before the July 1, 1993, deadline.

The committee recognizes that some of the pregnant women and infants who will qualify for Medicaid coverage under this bill are covered under employment-based health insurance coverage. As under current law, this coverage would be treated as a third party liability. In the case of all prenatal or preventive pediatric care (including EPSDT services) covered under the State's Medicaid plan, the State would first make payment for the services, under its usual payment schedule, and then seek recovery from the insurer. In the case of all other services, including inpatient hospital delivery, the insurer would pay first, and the State would pay only to the extent that the services were covered under the State plan and that the insurer was not liable.

As under current law, section 1902(l)(4)(A) of the Social Security Act, the mandatory phase-in of coverage for pregnant women and infants, and other mandates in the committee bill (including the phase-in of coverage of pregnant children, flexibility in income methodology, prohibition of a resource test, payment for obstetrical and pediatric services, role in paternity determinations, coordination with WIC, and outreach locations), apply to Arizona in the same manner as they apply to other States, notwithstanding the section 1115 waiver under which Arizona operates its Medicaid program.

This requirement would apply with respect to determinations (or redeterminations) of eligibility for Medicaid occurring on or after April 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by that date.

In the case of Texas, the requirement would not apply before September 1, 1991.

(b) *Flexibility in Income Methodology and Deduction of Child Care in Computation of Income.* Under current law, in determining income eligibility for pregnant women and infants, States are required to use the same methodology they use in determining income under their AFDC programs. One exception is that, regardless of the rules for AFDC purposes, States may not, for Medicaid eligibility purposes, deem available to the pregnant woman the income or resources of any grandparent or any sibling living in the same home with the pregnant woman or her infant. Another exception is that States must, for Medicaid eligibility purposes, treat a pregnant woman as though her child were born and living with her at the time she applies for benefits; thus, unlike AFDC, the smallest assistance unit in the case of a pregnant woman would, for Medicaid purposes, be a family unit of two.

The committee bill would allow States, at their option, to use less restrictive income methodologies than those employed under their AFDC programs. For this purpose, a methodology is no more restrictive if, under the alternate methodology, (1) additional pregnant women and infants may be eligible for Medicaid, and (2) no pregnant women or infants who would be eligible under the AFDC methodology would be made ineligible for Medicaid under the alternate methodology.

Under current law, in determining eligibility for cash assistance under AFDC, States are required to disregard child care costs of up to $160 per month per child. As of April 1, 1990, States will be required, in determining income eligibility for Medicaid transitional coverage for families leaving AFDC cash assistance due to employment, to disregard the costs of child care that are necessary for the employment of the caretaker relative. There is no cap on the amount of necessary child care costs that must be disregarded.

The purpose of the committee bill is to reduce infant mortality by assuring that low-income pregnant women, including working poor pregnant women, have financial access to needed prenatal and maternity care. If the minimum mandatory income thresholds in the bill—130 percent, 150 percent, 185 percent of poverty—were applied without regard to child care costs, the effect would be to force very difficult choices on working poor women whose gross incomes exceed the threshold, but whose incomes, net of child care costs, fall below the threshold. If they continue to work, these women and their children will be ineligible for Medicaid. Unless their employer offers private health insurance coverage, and unless they are able to afford this coverage despite their child care costs, they will be uninsured. On the other hand, if they stop working, or reduce their hours of employment so as to bring their income below the threshold, they will qualify for Medicaid.

In the view of the committee, the Medicaid eligibility determination process should encourage applicants to work rather than to seek cash assistance. Clearly, child care costs have a dramatic impact on the ability of working poor pregnant women to afford needed health care. To ignore these costs would be to create a significant work disincentive. Accordingly, the committee bill would require the States, in determining the income eligibility of preg-

nant women and infants under age 1, to disregard costs for such child care as is necessary for the employment of the pregnant woman or caretaker of the infant. The committee bill does not impose a limit on the amount of this child care deduction, and neither the Secretary nor the States has any authority to establish an absolute dollar limit on the amount of work-related child care costs that must be disregarded. Neither the Secretary nor the States is authorized to impose such a limit.

The committee intends that States, in determining income eligibility of pregnant women or infants for Medicaid coverage, disregard all child care costs necessary for employment. The committee expects that, in determining whether an expense is necessary for employment, the States will take full account of the costs of qualified child care in the woman's neighborhood and at her place of work. The committee stresses that the child care costs which must be taken into account in determining Medicaid eligibility of pregnant women are not limited to those that are recognized under the AFDC program (Title IV–A).

Both the option relating to income methodology, and the requirement relating to the deduction of child care costs, are effective for determinations (or redeterminations) of eligibility made on or after July 1, 1990, regardless of whether final regulations have been issued. In the case of Texas, the requirement would not apply until September 1, 1991.

(c) *Prohibiting Application of a Resource Test.* Under current law, States have the option of applying a resource test in determining Medicaid eligibility of pregnant women and infants. With respect to pregnant women, this test may be no more restrictive than that applied under the Supplemental Security Income (SSI) program; with respect to infants, no more restrictive than that applied under the State's Aid to Families with Dependent Children (AFDC) program.

According to the Children's Defense Fund, as of June, 1989, 43 States (including D.C.) had elected not to apply a resource test in determining the eligibility of pregnant women and infants. (Only California, Colorado, Illinois, Iowa, Missouri, North Dakota, Texas, and Wisconsin still applied resource tests). In its August, 1988, report, the National Commission on Preventing Infant Mortality recommended that assets tests for pregnant women be eliminated. The committee agrees. The committee bill would prohibit States, effective July 1, 1990, from imposing any resource standard or methodology in determining eligibility of pregnant women and infants for Medicaid coverage. This prohibition would apply with respect to all pregnant women and infants, whether they are currently covered under a mandatory or an optional eligibility provision. Thus, if a State, before July 1, 1993, elects to cover pregnant women and infants up to 185 percent of the poverty level, it may not apply resource tests to that population.

Resource requirements are basic to means testing for welfare benefits. However, they are fundamentally inconsistent with a public health initiative to reduce infant mortality. The committee's purpose is not to extend Medicaid benefits to individuals who, due to insufficient means, are considered "deserving." Instead, the purpose is to assure financial access to needed prenatal, maternity,

and pediatric care for low-income pregnant women and infants. As a large majority of the States have already recognized, resource tests introduce enormous complexity and substantial cost into the eligibility determination process. They also carry with them a welfare stigma that discourages pregnant women from accessing this coverage. In the view of the committee, all pregnant women and their infants are deserving; there is no need for a resource test to divide low-income pregnant women and infants into the deserving and the undeserving.

This provision would apply with respect to determinations (or redeterminations) of eligibility for Medicaid occurring on or after July 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by that date. In the case of Texas, the requirement would not apply before September 1, 1991.

(d) *Report and Transition on Errors in Eligibility Determinations.* Under current law, States are required to review the accuracy of eligibility determinations. Under this so-called "quality control" (QC) process, the State selects a monthly sample of cases for review and identifies cases where errors (other than technical errors) have resulted in payments for services on behalf of individuals who were not eligible or whose "spenddown" liability was underestimated. The State's error rate is the ratio of the Medicaid funds spent as a result of the error to the Medicaid funds spent for the entire sample. If this rate exceeds 3 percent, the State is subject to a reduction in Federal matching payments, unless the Secretary waives the disallowance because the State has made a good faith effort to comply. Expenditures for ambulatory prenatal care to pregnant women during a presumptive eligibility period are excluded from the calculation of erroneous payments.

The committee is concerned that the QC process has had an inadvertent chilling effect on the ability of low-income pregnant women and infants to establish promptly eligibility for Medicaid. As currently structured, the QC process focuses on penalizing States for extending coverage to individuals who are not eligible. The process does not impose penalties for erroneous denials of coverage to individuals who are in fact eligible. Thus, States have a strong incentive to establish the most stringent, time-consuming eligibility determination and verification procedures. States have no incentive to correct those procedures when they result in the delay or denial of coverage to individuals who are in fact eligible.

In the view of the committee, payment accuracy is an important goal of the Medicaid program, but it is not the only goal. A fundamental purpose of Medicaid is to improve the health status of the poor by assuring access to needed health care. One of the principal measures of health status is infant mortality. The committee is concerned that the QC process may be deterring States from making eligibility determinations in a timely and expeditious manner. Unnecessarily lengthy eligibility determination procedures are inconsistent with the program's objective of increasing access by low-income pregnant women and infants to needed prenatal, maternity, and well-child services in a timely manner.

The committee bill would require the Secretary to report to Congress, by not later than July 1, 1990, on error rates by the States in

determining Medicaid eligibility of pregnant women and infants. In addition to information from the current QC system, the report should contain information on the extent to which States erroneously deny or delay eligibility to pregnant women and infants who are in fact eligible for coverage. The report should also include recommendations for reducing the amount of time required by States to make accurate eligibility determinations with respect to these populations. To reduce the adverse incentives of the QC process while the Secretary studies this issue, the committee bill would exclude from the calculation of error rates any Medicaid expenditures attributable to pregnant women and infants made during the period beginning on July 1, 1989, and ending the first calendar quarter beginning more than 12 months after the Secretary submits the report.

Sec. 4202—Presumptive Eligibility

Under current law, States have the option to offer coverage for ambulatory prenatal care to pregnant women who have been determined to be presumptively eligible for Medicaid. Generally, the coverage extends through a presumptive eligibility period, which ends on the earlier of (1) the date on which a final eligibility determination is made or (2) 45 days after the determination of presumptive eligibility. If a woman does not file an application for Medicaid within 14 days after being determined presumptively eligible, her coverage terminates at that point.

The purpose of this option is to avoid delays in access of low-income women to needed prenatal care while their formal applications for Medicaid eligibility are being considered. Presumptive eligibility determinations are made by certain providers of outpatient or clinic services, such as federally-funded community health centers. According to the National Governors' Association, as of January, 1989, 20 States had implemented the presumptive eligibility option.

(a) *Extension of Presumptive Eligibility Period.* It is the understanding of the committee that the rigid timeframe under current law has discouraged some States from adopting the presumptive eligibility option, despite the obvious benefits of making medically necessary outpatient services available to low-income pregnant women during the critical prenatal period while the State processes their formal applications for full Medicaid eligibility. In order to make the presumptive eligibility option more attractive to the States, the committee bill provides that the presumptive eligibility period ends with (and includes) the earlier of (1) the day on which a final eligibility determination is made or (2) in the case of a woman who does not file an application by the last day of the month following the month during which she is determined to be presumptively eligible, that last day. This modification is effective for ambulatory prenatal services provided on or after July 1, 1990.

This modification would have the following effect. First, the current 45-day limit on the presumptive eligibility period would be eliminated. Thus, if a State took more than 45 days to process a woman's Medicaid application, coverage for ambulatory prenatal care would continue without interruption until the day the State makes a final eligibility determination. Second, a pregnant woman

would have at least 1 month, and as much as 2 months, during which to file the formal application for Medicaid coverage. Thus, if a woman was determined presumptively eligible on June 15, she would have until July 31 to file her formal Medicaid application. This will avoid the loss of presumptive eligibility solely because a low-income pregnant woman is unable to meet the current 2-week deadline for filing what can be an extremely complicated eligibility form.

(b) *Flexibility in Application.* It is the understanding of the committee that a number of States have been advised by the Health Care Financing Administration that they must use different application forms for presumptive eligibility determinations and for final Medicaid eligibility determinations. There is no basis for this assertion. The committee bill clarifies that a State has, and always has had, the option to use the same application form for presumptive eligibility purposes as it uses to determine final Medicaid eligibility for pregnant women.

Sec. 4203—Optional Coverage of Prenatal and Postpartum Home Visitation Services

Under current law, Federal Medicaid matching funds are available for payments made by States, at their option, to physicians, nurses, and other health professionals, for delivering services in locations other than their offices or clinics. In its August, 1988, report, the National Commission on the Prevention of Infant Mortality recommended the establishment of a "home visitors program" for high-risk pregnant women and new mothers which would educate and work with these women during their pregnancies to promote healthy outcomes by encouraging appropriate behavior and making referrals to needed services.

In order to provide States with a stable source of funding for such programs, the committee bill would establish a new optional Medicaid benefit: prenatal home visitation services for high-risk pregnant women (as prescribed by a physician) and/or postpartum home visitation services with respect to high-risk infants under 1 (as prescribed by a physician). States would have the option to cover these services during the prenatal period, the post-partum period, or both. States would have the discretion to define "high-risk" for purposes of this benefit and could include in their definition both medical and social risk of an adverse pregnancy or birth outcome. Home visitation services, whether prenatal or postpartum, would have to be prescribed by a physician, but could actually be provided by a nurse, a nurse practitioner, health educator, or other health professional. The scope of the home visitation benefit would be defined by the State, but could include, in addition to medical services, other services designed to improve the outcome of the pregnancy or the health of the infant, including in-home health assessments under the EPSDT program, health education, and parenting training.

This optional benefit would be effective July 1, 1990, regardless of whether the Secretary has issued implementing regulations. The committee expects that the Secretary, in developing interpretive guidelines or regulations, will make every effort to avoid placing limitations on the availability of Federal Medicaid matching funds

that might prevent the States from providing a service that has the potential for improving pregnancy outcomes among low-income women or the health status of their infants.

Sec. 4204—Payment for Obstetrical and Pediatric Services

Under current law, States have discretion in establishing payment rates and methodologies for physician services under their Medicaid programs. Payments to physicians, like payments to other practitioners, must be consistent with efficiency, economy, and quality of care. By regulation, 42 C.F.R. 447.204, the Secretary has required that payment levels for providers be sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population.

The Subcommittee on Health and the Environment heard testimony that Medicaid participation of physicians generally, and obstetricians and pediatricians in particular, is inadequate. A physician's decision to accept Medicaid patients is affected by many factors, including perceived malpractice risk, administrative burdens (prior authorization requirements, paperwork, etc.), discontinuous eligibility, and delays in processing and paying claims. Another important factor is the payment rate itself. As the National Governors' Association testified before the Subcommittee on Health and the Environment on February 8, 1989, "There is no doubt that Medicaid reimbursement rates have not kept pace with average community rates. States have restrained physician fees as one method of controlling program costs. Studies have shown that the fees paid by Medicaid to obstetricians and gynecologists have had an impact on their participation in the program."

Available data provides overwhelming support for the Governors' views. In testimony submitted to the subcommittee, the Children's Defense Fund calculated that, as of April, 1988, Medicaid fees for a vaginal delivery ranged from a low of 21 percent of the average regional physician charge in New Jersey to a high of 131 percent Massachusetts. Medicaid fees for a Cesarean section ranged from 30 percent of the average regional physician charge in Vermont to 110 percent Massachusetts.

In the view of the committee, the Medicaid eligibility expansions contained in the committee bill for poor pregnant women and infants (section 4201) and poor children (section 4211) will not have their intended effect if physicians are not willing to treat Medicaid patients. The committee recognizes that payment levels are only one determinant of physician participation. However, the committee believes that, without adequate payment levels, it is simply unrealistic to expect physicians to participate in the program, particularly when so many of them believe that Medicaid patients present a greater liability risk.

(a) *Codification of Adequate Payment Level Provisions.* The committee bill would codify, with one clarification, the current regulation, 42 C.F.R. 447.204, requiring adequate payment levels. Specifically, the committee bill would require that Medicaid payments for all practitioners be sufficient to enlist enough providers so that care and services are available under the plan at least to the

extent that such care and services are available to the general population in the geographic area.

The committee bill clarifies that the equal access test is to be applied in relation to the supply of providers in a geographic area. Thus, if a particular geographic area within a State has a smaller number of physicians per thousand insured population than other parts of the State, or than the State as a whole, the Medicaid payments would have to be at a level that ensures that Medicaid beneficiaries in that area have at least the same access to physicians as the rest of the insured population in that area. The committee bill would not require that Medicaid payment levels be high enough to induce physicians to relocate into this area.

The committee expects that the Secretary, in determining whether services are available to Medicaid beneficiaries at least to the extent that services are available to the general population, will compare the access of beneficiaries to the access of other individuals in the same geographic area with private or public insurance coverage (whether in the form of indemnity, service, or prepaid benefits). It is obvious that Medicaid beneficiaries are likely to have better access to care than individuals without insurance coverage and without the ability to pay for services directly. The question which the Secretary must ask is whether Medicaid beneficiaries have access to provider services that is at least as great as that of others in the area who have third party coverage.

(b) *Assuring Adequate Payment Levels for Obstetrical and Pediatric Services.* In the view of the committee, if infant mortality is to be reduced and child health status improved, it is essential that States comply fully with the adequate payment requirement with respect to obstetrical and pediatric services. The committee bill therefore requires States, by not later than April 1 of each year, to submit a State Medicaid plan amendment that specifies the payment rates to be used for obstetrical services and for pediatric services during the 12-month period beginning July 1 of that year. These plan amendments may be filed separately or combined. For this purpose, obstetrical services are defined as non-institutional services relating to pregnancy provided by an obstetrician, obstetrician-gynecologist, family practitioner, certified nurse midwife, or certified family nurse practitioner. Similarly, pediatric services are defined as noninstitutional services to children under 18 provided by a pediatrician, family practitioner, or certified pediatric nurse practitioner.

The April 1 submission must include additional data, specified by the Secretary, needed to evaluate the State's compliance with the adequate payment requirement. In order to assure that payments to HMO's and other entities with which the State contracts on a risk basis (whether or not under waiver) provide adequate resources for the delivery of quality obstetrical and pediatric services, the committee bill requires that the data submitted by the State include information on how payment rates to HMO's and other risk contractors compare with the State's fee-for-service payment rates for obstetrical and pediatric services.

Within 90 days after the submission of a plan amendment by the State relating to obstetrical and/or pediatric services, the Secretary must review the amendment for compliance with the adequate pay-

ment requirement and approve or disapprove it. In the event of a disapproval, the State must immediately submit a revised amendment which meets the requirement. The committee expects that, in reviewing State plan amendments, the Secretary will make certain that payment levels are in fact sufficient to induce physicians to participate in the program so that Medicaid-eligible pregnant women, infants, and children will have access to needed obstetrical and pediatric services.

To enable the Secretary and the States to more accurately gauge compliance with the adequate payment requirement, the committee bill requires that, beginning with the submission due April 1, 1992, States set forth at least the statewide average payment rates for the second previous year (e.g., July 1, 1990 through June 30, 1991) for obstetrical services. These payment rates must be broken down by procedure, by type of provider (e.g., obstetricians, obstetrician-gynecologists, family practitioners, certified family nurse practitioners, and certified nurse midwives), and by practice area (e.g., metropolitan statistical areas and all other areas). The committee bill imposes a parallel reporting requirement beginning in 1992 with respect to pediatric services. Again, statewide average payment rates must to be identified by procedure, by type of provider (pediatrician, family practitioner, and certified pediatric nurse practitioner), and urban and rural practice areas.

The committee recognizes that access to obstetrical or pediatric services may be particularly problematic in rural areas, and that a State may wish to structure its Medicaid payments so as to encourage physicians who are now practicing in these areas to continue doing so, and to induce those who are not now practicing in these areas to relocate. The committee bill clarifies that nothing in the Medicaid statute is to be construed to prevent a State from establishing payment levels for obstetrical or pediatric services in rural areas that are higher than those established for these same services in metropolitan statistical areas.

(c) *Payment for Certain Services in Certain Federally-Funded Health Centers.* Under current law, States are required to cover rural health clinic services (and any other ambulatory services offered by rural health clinics), and to set payment levels at 100 percent of the reasonable costs of delivering these services. States also have the option of offering coverage for clinic services; if they elect to do so, they are not required to set payment levels at 100 percent of reasonable cost.

Among the providers of clinic services are community health centers, migrant health centers, and health care for the homeless programs funded under sections 330, 329, and 340 of the Public Health Service (PHS) Act, respectively. There are over 550 of these federally-funded centers in urban and rural areas throughout the country. In 1987, they delivered primary care services to about 5.7 million people, including 2.5 million children under 18 and 1.6 million women of childbearing age. That year, health center patients accounted for about 10 percent of all births nationally to low-income women.

According to a June, 1989, study prepared for the National Association of Community Health Centers, all but one State has opted to cover clinic services of some kind; however, only 24 of 38 States

surveyed pay for clinic services delivered by federally funded health centers or programs. Of these, only the District of Columbia, Kentucky, North Carolina (subject to a cap), South Carolina, and Tennessee reimburse health centers on a cost basis. (In other States, centers may be paid on the basis of a prospective rate or on a fee basis; States may also treat physicians at a center as a group practice for reimbursement purposes).

The Subcommittee on Health and the Environment heard testimony that, on average, Medicaid payment levels to federally-funded health centers cover less than 70 percent of the costs incurred by the centers in serving Medicaid patients. The role of the programs funded under sections 399, 330, and 340 of the PHS Act is to deliver comprehensive primary care services to underserved populations or areas without regard to ability to pay. To the extent that the Medicaid program is not covering the cost of treating its own beneficiaries, it is compromising the ability of the centers to meet the primary care needs of those without any public or private coverage whatsoever.

The committee bill would require States, under their Medicaid programs, to cover ambulatory services offered to pregnant women or children under 18 by a health center or program receiving funds (in whole or in part, directly or by subgrants) under section 329, 330, or 340 of the PHS Act. The committee intends that the term "ambulatory services" be construed to include any outpatient service which the center is authorized to provide under section 329, 330, or 340 of the PHS Act. The committee recognizes that, in some States, ambulatory services offered by a health center or program may be broader in scope than outpatient services offered by other classes of providers; nonetheless, the State would still be required to cover the broader range of services when provided by a health center or program. For example, if a center provides home visitation services for high-risk pregnant women or infants, the State would have to pay for those services even if the State does not cover home visitation services furnished by any other class of provider, such as physicians, nurses, or nurse practitioners.

To ensure that Federal PHS Act grant funds are not used to subsidize health center or program services to Medicaid beneficiaries, States would be required to make payment for these services at 100 percent of the costs which are reasonable and related to the cost of furnishing these services. This cost reimbursement requirement applies to all ambulatory services offered by the center or program, not just those included in the current law definition of rural health clinic services. The committee expects that, in determining reasonableness, the Secretary and the States will use data on the actual costs incurred by health centers or programs in delivering ambulatory care.

These requirements are effective on July 1, 1990, without regard to whether or not the Secretary has promulgated final regulations.

Sec. 4205—Role in Paternity Determinations

Under current law, States must require all applicants for Medicaid, as a condition of eligibility, to cooperate with the State in establishing paternity and in obtaining child support. The State may

waive this requirement if it determines that the individual has good cause for refusing to cooperate.

The committee is concerned that application of these requirements to women who are applying only for pregnancy-related coverage may discourage many of them from seeking benefits that would give them access to early prenatal care. The committee notes that the Department's own manuals acknowledge that paternity determinations, which are based on one of several blood tests, cannot be made before an infant is at least 4 months old: "Blood must be drawn in sufficient quantity for the particular test to be performed....This may impose a mandatory delay in a case involving a newborn infant because it is difficult to obtain any significant volume of the baby's blood. Many technicians require that a child be 4 to 6 months old and be in good health before they will attempt to obtain a blood sample....Some laboratories will not draw blood for [one type of] testing unless the child is at least 12 months old. For the other tests [for paternity determination], it is generally prudent to avoid venipuncture until the child is 6 months old. An additional advantage in waiting this long after birth is the assurance that antigens in the blood are fully developed by this age." U.S. Department of Health and Human Services, Office of Child Support Enforcement, *A Guide for Judges in Child Support Enforcement* (1983) at pages 51–52.

Thus, the cooperation requirement is not only a potential barrier to prenatal care for the high-risk, low-income women that would most benefit from it, but it is also a bureaucratic hurdle that yields absolutely no useful information until months after the prenatal period has ended. The committee bill therefore exempts pregnant women applying for Medicaid on the basis of their pregnancy and low income from the cooperation requirements with respect to establishing paternity and obtaining child support.

Sec. 4206—Required Medicaid Notice and Coordination with Special Supplemental Food Program for Women, Infants, and Children (WIC)

The Special Supplemental Food Program for Women, Infants, and Children (WIC), which is not within the jurisdiction of this committee, serves low-income pregnant women, infants, and children under 5 who are determined by a medical professional to be at nutritional risk and who have incomes at or below 185 percent of the Federal poverty level. Women and children eligible for WIC receive nutrition assistance (including vouchers to purchase iron-fortified cereals, infant formula or milk, eggs, juice, peanut butter), nutrition education, and some health-related services.

The National Commission on the Prevention of Infant Mortality identified WIC as one of the programs to which high-risk pregnant women should have early access. Under the committee bill, which would raise the income eligibility threshold under Medicaid to that of WIC over the next 4 years, the logic of coordinating the two programs becomes even more compelling. Under current law, the State's WIC program must include "a plan to coordinate operations under the program with . . . maternal and child health care, and Medicaid programs." While the Medicaid program is currently required to enter into agreements with providers receiving funds

under the Title V Maternal and Child Health Block Grant, there is no reciprocal coordination requirement with respect to WIC.

The committee bill would require States to coordinate their operations under Medicaid with their operations under WIC. In addition, States would be required to notify all women who are pregnant, breast-feeding, or postpartum, and all children below age 5, who are eligible for Medicaid, of the availability of WIC benefits. This notification must occur in a timely manner, either at the time of a determination that a woman is eligible (or presumptively eligible) for Medicaid, or immediately thereafter. The State must also provide for the referral of Medicaid-eligible women and children under 5 to the State agency responsible for administering WIC. This referral could be achieved at the same time as notification. The costs which States incur in carrying out these coordination responsibilities are necessary for the proper and efficient administration of the State Medicaid plan, and as such are subject to Federal matching at a 50 percent rate.

PART B—CHILD HEALTH AMENDMENTS

Sec. 4211—Phased-In Mandatory Coverage of Children Up to 100 Percent of Poverty Level

(a) *In General.* Under current law, States are required to offer Medicaid coverage to all children born after September 30, 1983, in families with incomes and resources below State AFDC standards, up to age 7. States are also required, as of July 1, 1990, to cover all infants up to age 1 in families with incomes below 100 percent of the Federal poverty level. In addition, States have the option of extending coverage to all children born after September 30, 1983, in families with incomes below 100 percent of the Federal poverty level, up to age 8. With respect to this poverty level group, States have the option of applying a resource test; if they do so, the resource standard and methodology may be no more restrictive than that under the State's AFDC program. As indicated in Table 1, as of January, 1989, 21 States had elected to cover children in poverty below ages 2 through 4, and 14 had elected to cover all poor children below ages 5 through 7.

As the Office of Technology Assessment documented in *Healthy Children: Investing in the Future* (1988), some preventive and other health care services for infants and children, notably newborn screening and immunizations, are cost-effective and can improve health status. Medicaid, with its early and periodic screening, diagnostic, and treatment (EPSDT) services benefit, is the major source of financing for preventive health care services for low-income children. Yet, according to the Congressional Research Service, Medicaid in 1986 reached only about half of all children in families with incomes below the poverty level; because of limited private health insurance coverage among the poor, about one third of all poor children were left with no public or private insurance coverage whatsoever *(Medicaid Source Book: Background Data and Analysis* (Committee Print 100–AA), p. 333).

To fill this coverage gap incrementally, the committee bill would convert the existing option to extend Medicaid coverage to poor children into a mandate. The bill would require States to extend

Medicaid coverage to all children born after September 30, 1983, in families with incomes below the Federal poverty level ($10,060 for a family of 3 in 1989), incrementally up to age 18. Under section 4201(c) of the bill, States would not have the option of applying a resource test to this population. This requirement would be effective July 1, 1990, except in Texas, when the requirement would apply on September 1, 1991. As under current law with respect to infants under age 1, this requirement would also apply to a State like Arizona that provides Medicaid coverage under a waiver under section 1115 of the Social Security Act.

The effect of this requirement is to phase in, over the next 12 years, mandatory Medicaid coverage for all poor children under 18. On July 1, 1990, all States would have to cover children born after September 30, 1983, in families with incomes below the poverty level, regardless of whether the family had one parent or two, and regardless of whether the family's resources exceeded the AFDC standard. On that date, the oldest of this cohort would be nearly 6¾ years old. As these children grew older, if their families remained poor, they would continue to be entitled to Medicaid coverage. By the year 2001, all States would be required to cover all poor children under age 18. The committee notes that States that want to extend coverage more quickly may elect, under the current law "Ribicoff child" option, to cover all children under age 21 whose family incomes and resources do not exceed AFDC levels.

Under the committee bill, in determining income eligibility for these children, States would be allowed to use a methodology that is less restrictive than that employed under the AFDC program. As under current law, they could not use a methodology for determining income that is more restrictive than that under AFDC. In addition, States would be required to disregard all costs for child care necessary for the employment of the child's parents or other caretaker relative.

(b) *Applications Using Outreach Locations.* Under current law, States have the option of accepting and processing applications for Medicaid eligibility at locations other than State or local welfare offices. (This option is in addition to the presumptive eligibility option, under which States designate certain providers to make presumptive determinations of eligibility with respect to pregnant women in order to expedite coverage for prenatal care). Many States currently station eligibility workers in hospitals, clinics, WIC clinics, and similar locations in order to enroll poor women and children in the program.

The committee is concerned that, unless poor women and children are able to apply for Medicaid in locations other than welfare offices, many of them will be deterred from obtaining the health care coverage they need in order to receive preventive health services. The committee bill would therefore require States to provide for the receipt and initial processing of applications for Medicaid coverage by poor pregnant women, infants, and children (whether optional or mandatory) at outreach locations such as hospitals and clinics that provide covered services to these populations. In designating hospitals or clinics for this purpose, States must include both public and private entities.

The committee bill does not require States to station eligibility workers at each and every hospital, clinic, and WIC program; however, the committee does intend that, at a minimum, eligibility workers be stationed on a full-time basis in each of the hospitals (such as disproportionate share facilities) and clinics that treat significant numbers of low-income women, infants, and children. These eligibility workers could be employees of the welfare agency, contractors to the agency, or employees of, or contractors to, the hospital, clinic, or other outreach location. As under current law, all costs incurred by the State with respect to the receipt and processing of Medicaid applications at these locations, including the salaries and equipment costs of eligibility workers, would, under the committee bill, be considered necessary for the proper and efficient administration of the State plan and subject to Federal matching payments at a 50 percent rate.

The committee is concerned that the lengthy, complex application forms for AFDC eligibility can create a barrier to access for women and children who are not seeking cash assistance, but only Medicaid coverage. Much of the information relevant to eligibility for cash assistance, such as resources and family composition, are not relevant to the coverage groups mandated under sections 4201(a) and 4211(a). The committee bill would therefore require States to provide for the use of applications for Medicaid-only coverage at the hospitals, clinics, and other outreach locations that the State designates under the previous requirement.

Under these requirements, the committee expects the eligibility determination process for low-income pregnant women, infants, and children to work as follows. States would develop application forms for use at designated hospitals, clinics, and other outreach locations. These simplified forms would contain only those information requirements necessary to determine eligibility for Medicaid. This information would include verification of the woman's pregnancy; age of the child (which could be provided through methods other than a formal birth certificate, such as verification from a hospital or from a child's health care provider regarding the child's date of birth); size and income of the family; verification of lawful residence in the United States; information concerning third party liability; and, in the case of children only, disclosure of paternity information in circumstances where such information is applicable. States using initial intake applications that included this information would not be required to use separate applications for making final eligibility determinations.

The entire application process could be conducted at the hospitals, clinics, and other outreach locations. If the eligibility worker at the outreach location is a welfare agency employee or contractor, the final eligibility determination could be made at that location. However, even if the eligibility worker is an employee of the hospital or clinic, the pregnant woman or child would not be required to go to the welfare office for a face-to-face interview in order to complete the eligibility determination process. Instead, the simplified application form, along with necessary documentation, would then be forwarded to the welfare office for a final determination.

Sec. 4212—Extension of Medicaid Transition Coverage

Under current law, States are required, effective April 1, 1990, to extend Medicaid coverage for 12 months to families who lose AFDC benefits due to earnings, and who continue to report earnings during this period. During the first 6 months of the transition period, States may not impose any premium requirement for this coverage; during the second 6 months, States may, at their option, impose an income-related premium. This requirement is repealed on September 30, 1998.

This Medicaid transitional coverage requirement was one of the provisions of the Family Support Act of 1988 (Public Law 100–460) designed to encourage families to leave welfare and become self-sufficient. Many of these former welfare recipients are employed in low-wage jobs that do not offer health insurance coverage. According to a General Accounting Office study, more than half of former welfare recipients who work are uninsured *(Evaluation of 1981 AFDC Changes: Final Report* (GAO/PEMD–85–4, July, 1985)). The committee is concerned that, in many cases, 12 months is not sufficient time for a mother to make the transition from welfare to a job that offers health insurance coverage for her and her children.

To further encourage welfare families to work, the committee bill would allow the States, at their option, to extend the current 12-month transitional coverage period for an additional 12 months (or 3, 6, or 9 months, as the State elects). Thus, a State could offer a working welfare family a total of 24 months of transitional Medicaid coverage (12 mandatory, 12 optional). Under the bill, the structure of the current mandatory benefit would remain unchanged. Thus, States could, at their option, impose the same income-related premium during this optional 12-month period that they are allowed to impose during the 2nd mandatory 6-month period. The committee bill would also repeal the sunset.

The committee bill would also make some technical corrections to current law. It clarifies that Medicaid transition coverage terminates at the close of the first month in which the family ceases to include a child, whether or not the child is a dependent child under part A of Title IV, or would be if needy. The committee bill also clarifies that families who, prior to April 1, 1990, are receiving Medicaid extension coverage under the current law 9-month provision are entitled to continue receiving this extension coverage after that date until their 9-month coverage period expires.

Sec. 4213—Early and Periodic Screening, Diagnostic, and Treatment Services

(a) *In General.* Under current law, States are required to offer early and periodic screening, diagnostic, and treatment (EPSDT) services to children under age 21. States are required to inform all Medicaid-eligible children of the availability of EPSDT services, to provide (or arrange for the provision of) screening services in all cases when they are requested, and, to arrange for (directly or through referral to appropriate agencies or providers) corrective treatment for which the child health screening indicates a need.

The EPSDT benefit is, in effect, the Nation's largest preventive health program for children. Each State must provide, at a mini-

mum, the following EPSDT services: assessments of health, developmental, and nutritional status; unclothed physical examinations; immunizations appropriate for age and health history; appropriate vision, hearing, and laboratory tests; dental screening furnished by direct referrals to dentists, beginning at age 3; and treatment for vision, hearing, and dental services found necessary by the screening. These services are available to children under EPSDT even if they are not available to other Medicaid beneficiaries under the State's plan.

The EPSDT benefit is not currently defined in statute. In the view of the committee, as Medicaid coverage of poor children expands, both under current law and under the committee bill, the EPSDT benefit will become even more important to the health status of children in this country. The committee bill would therefore define the EPSDT benefit in statute to include four distinct elements: (1) screening services, (2) vision services, (3) dental services, and (4) hearing services. Each of these service elements would have its own periodicity schedule that meets reasonable practice standards. These items and services must be covered for children even if, under the State Medicaid plan, they are not offered to other groups of program beneficiaries.

Under the committee bill, screening services must, at a minimum, include (1) a comprehensive health and developmental history (including assessment of both physical and mental health development), (2) a comprehensive unclothed physical exam, (3) appropriate immunizations according to age and health history, (4) laboratory tests (including blood lead level assessment appropriate for age and risk factors), and (5) health education (including anticipatory guidance). The committee emphasizes that anticipatory guidance to the child (or the child's parent or guardian) is a mandatory element of any adequate EPSDT assessment. Anticipatory guidance includes health education and counselling to both parents and children.

Under the committee bill, vision services must, at a minimum, include diagnosis and treatment for defects in vision, including eyeglasses. Dental services must, at a minimum, include relief of pain and infections, restoration of teeth, and maintenance of dental health. Hearing services must, at a minimum, include diagnosis and treatment for defects in hearing, including the provision of hearing aids. While States may use prior authorization and other utilization controls to ensure that treatment services are medically necessary, these controls must be consistent with the preventive thrust of the EPSDT benefit. For example, States may not limit dental care to emergency services only, *Mitchell* v. *Johnston,* 701 F. 2d 337 (5th Cir. 1983).

The committee bill also clarifies the periodic nature of EPSDT services. With respect to screening services, the bill requires that they be provided at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations. The committee intends that these health examinations be provided at intervals that are no greater than those described for well-child care in the *Guidelines for Health Supervision* (1981) of the American Academy of Pediatrics. The committee is informed that some

States use periodicity schedules for medical examinations to govern the frequency with which children may receive dental examinations. The committee intends that, among older children, dental examinations occur with greater frequency than is the case with physical examinations.

The committee bill also requires States to provide screening services at intervals other than those identified in their basic periodicity schedule, when there are indications that it is medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. These interperiodic screening examinations may occur even in the case of children whose physical, mental, or developmental illnesses or conditions have already been diagnosed, if there are indications that the illness or condition may have become more severe or has changed sufficiently, so that further examination is medically necessary. The committee emphasizes that the determination of whether an interperiodic screening is medically necessary may be made by a health, developmental, or educational professional who comes into contact with a child outside of the health care system (e.g., State early intervention or special education programs, Head Start and day care programs, WIC and other nutritional assistance programs). As long as the child is referred to an EPSDT provider, the child would be entitled to an interperiodic health assessment (or dental, vision, or hearing assessment) or treatment services covered under the State plan.

These same considerations apply with respect to vision, dental, and hearing services, all of which must be provided when indicated as medically necessary to determine the existence of suspected illnesses or conditions. For example, assume that a child is screened at age 5 according to a State's periodicity schedule and is found to have no abnormalities. At age six, the child is referred to the school nurse by a teacher who suspects the child of having a vision problem. Under the committee bill, the child can—and should—be referred at that point to a qualified provider of vision care for full diagnostic and treatment services, and the State must make payment for those services, even though the next regular vision exam under the State's periodicity schedule does not occur until age 7.

While States may, at their option, impose prior authorization requirements on treatment services, the committee intends that, consistent with the preventive thrust of the EPSDT benefit, both the regular periodic screening services and the interperiodic screening services be provided without prior authorization.

The committee notes that Medicaid-eligible children are entitled to EPSDT benefits even if they are enrolled in a health maintenance organization, prepaid health plan, or other managed care provider. The committee expects that States will not contract with a managed care provider unless the provider demonstrates that it has the capacity (whether through its own employees or by contract) to deliver the full array of items and services contained in the EPSDT benefit. The committee further expects that, in setting payment rates for managed care providers, the States will make available the resources necessary to conduct the required periodic and interperiodic screenings and to provide the required diagnostic and screening services.

The committee bill clarifies that States are without authority to restrict the classes of qualified providers that may participate in the EPSDT program. Providers that meet the professional qualifications required under State law to provide an EPSDT screening, diagnostic, or treatment service must be permitted to participate in the program even if they deliver services in school settings, and even if they are qualified to deliver only one of the items or services in the EPSDT benefit.

(b) *Report on the Provision of EPSDT.* In order to assess the effectiveness of State EPSDT programs in reaching eligible children, the committee bill would require the States to report annually to the Secretary, in a uniform form and manner established by the Secretary, the following information, broken down by age group and by basis of eligibility for Medicaid: (1) the number of children receiving child health screening services; (2) the number of children referred for corrective treatment (the need for which is disclosed by the screening); and (3) the number of children receiving dental services. These reports would be due April 1 of each year (beginning with April 1, 1991) and would apply to services provided during the Federal fiscal year ending the previous September 30 (beginning with fiscal year 1990).

Sec. 4214—Extension of Payment Provisions for Medically Necessary Services in Disproportionate Share Hospitals

(a) *Coverage of Medically Necessary Services for Children.* Under current law, States may impose reasonable limits on the amount, duration, and scope of covered services. However, effective July 1, 1989, States are prohibited from imposing any fixed durational limit on Medicaid coverage of medically necessary inpatient hospital services provided to infants under age 1 by disproportionate share hospitals. As of January, 1989, according to the National Association of Childrens' Hospitals and Related Institutions, 14 States imposed durational limits on inpatient hospital services for children (Alabama, Alaska, Arkansas, California, Florida, Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, Oregon, Tennessee, Texas, and West Virginia).

The purpose of the current law exception to fixed durational limits is to prohibit States from using arbitrary length of stay limitations (e.g., 20 days per year) to reduce payments for medically necessary services provided by hospitals, including many public and childrens' hospitals, that serve a disproportionate number of low-income patients. The committee bill would extend this current law prohibition to any fixed durational limits on payment for inpatient services provided to children under age 18 by disproportionate share hospitals. This requirement is effective for inpatient hospital services furnished on or after July 1, 1990.

(b) *Assuring Adequate Payment for Inpatient Hospital Services for Children in Disproportionate Share Hospitals.* Under current law, States may reimburse hospitals for inpatient services on a prospective basis. If they choose to do so, States must, effective July 1, 1989, provide for an outlier adjustment in payment amounts for medically necessary inpatient services provided by disproportionate share hospitals involving exceptionally high costs or exceptionally long lengths of stay for infants under 1 year of age. According to

the National Association of Children's Hospitals and Related Institutions, as of January, 1989, a total of 44 States pay for inpatient hospital services on a prospective basis; only 15 made outlier adjustments for high cost or long-stay cases (Alabama, Arkansas, California, Colorado, Connecticut, D.C., Florida, Kentucky, Mississippi, Missouri, Nevada, New Hampshire, Oklahoma, Tennessee, and Texas).

The committee bill would extend this current law requirement to cases involving children from age 1 up to age 18. States that pay for inpatient hospital services on a prospective basis would be required to submit to the Secretary, no later than April 1, 1990, a State plan amendment that provides for an outlier adjustment in payment amounts for medically necessary inpatient services provided by disproportionate share hospitals after July 1, 1990, involving exceptionally high costs or exceptionally long lengths of stay for children age 1 up to age 18.

Sec. 4215—Requiring "Section 209(b)" States to Provide Medical Assistance to Disabled Children Receiving SSI Benefits

Under current law, States have the option of requiring aged, blind, and disabled individuals receiving Supplemental Security Income benefits to meet eligibility criteria more restrictive than those under SSI in order to qualify for Medicaid. States that elect this "209(b)" option must use eligibility criteria that were in lawful and in effect in that State on January 1, 1972.

While many of these "209(b)" States use more restrictive financial eligibility criteria, the committee understands that 4 of these States (Connecticut, Minnesota, Missouri, and New Hampshire) exclude from Medicaid coverage disabled children under 18 who receive SSI benefits, because the January, 1972, Aid to the Blind and Disabled Programs did not cover disabled children. Under existing precedent, disabled children may not be excluded from Medicaid coverage if they are also eligible for AFDC, *West* v. *Cole,* 390 F. Supp. 91 (N.D. Miss. 1975). However, in the case of a disabled child not categorically related to AFDC, a "209(b)" State may exclude such a child from Medicaid coverage because eligibility criteria that were in effect in January, 1972, did not recognize disabled children.

The committee bill would require all "209(b)" States to provide Medicaid to any child under 18 who is receiving (or on whose behalf are being paid) SSI benefits. This will prohibit "209(b)" States from excluding disabled children receiving SSI from Medicaid coverage. This requirement would be effective on July 1, 1990, without regard to whether or not final implementing regulations have been promulgated.

Sec. 4216—Mandatory Continuation of Coverage for Children Otherwise Qualified for Benefits Until Redetermination

Under current law, there are several bases on which poor children may qualify for Medicaid. Most children eligible for Medicaid qualify as mandatory categorically needy because they are in families that receive AFDC benefits. Other children who meet the AFDC categorical requirements, but whose families have incomes and resources greater than the AFDC standards, may, by incurring

medical expenses, qualify as medically needy. There are also various optional categorically needy groups, such as infants in families with incomes between 100 and 185 percent of the Federal poverty level, or children born after September 30, 1983, in families with incomes below 100 percent of poverty.

The committee is concerned that the constant turnover in AFDC caseloads may result in the interruption of Medicaid coverage for children who are eligible based on their age and their family's poverty income. Courts have prohibited States from terminating eligibility for Medicaid on one basis without first redetermining an individual's continued eligibility on another basis. See, e.g., *Stenson* v. *Blum,* 476 F. Supp. 1331 (S.D.N.Y. 1979), aff'd, 628 F.2d 1345 (2d Cir. 1980), cert. denied, 449 U.S. 885 (1980); *MAOA* v. *Sharp,* 700 F.2d 749 (1st Cir. 1983).

In order to assure continuity in Medicaid coverage for eligible children, the committee bill clarifies that States may not discontinue Medicaid coverage to children under 18 until the State has determined that the child is not eligible for Medicaid on any basis. The committee stresses that the determination as to whether a child is eligible on some other basis must take place before eligibility is terminated; States may not terminate eligibility and then require the child to reapply for benefits. For example, in a case where a child loses AFDC because of a change in income or resources, a State would be required, before terminating the child's Medicaid coverage, to determine whether the child is eligible for coverage on some other mandatory basis (e.g., the coverage group established under section 4211(a) of the committee bill) or on an optional basis (e.g., if covered under the State plan, medically needy, financially needy, or poverty percentage children).

The committee bill provides that, in determining erroneous payments for the purpose of "quality control," the Secretary may not include any expenditures attributable to children under 18 who are determined to be ineligible for Medicaid on one basis but whose Medicaid coverage has not been discontinued because a determination on other bases has not been made. The purpose of this provision is to protect the State from any "quality control" penalties for expenditures made on behalf of children under 18 during the period between the determination of ineligibility on one basis and the determination of eligibility or ineligibility on any other basis. The committee emphasizes that even if a child proves to be ineligible for coverage on any other basis, Medicaid expenditures made on behalf of the child after the initial determination of ineligibility on one basis (but before the determination of ineligibility on any other basis) are not to be included in the calculation of a State's error rates for "quality control" purposes, and a State is not subject to a reduction in Federal matching payments as a result of such expenditures.

Sec. 4217—Optional Medicaid Coverage for Foster Children

Under current law, States are required to offer Medicaid to children receiving foster care maintenance payments under Title IV–E. In addition, States may also provide Medicaid to foster children under the "Ribicoff child" option, which allows States to extend Medicaid coverage to all children under 21 (or, at State option,

under age 20, 19, or 18) whose families do not meet the AFDC categorical requirements but whose family incomes and resources are below State AFDC eligibility levels. Current Federal regulations allow States to limit coverage to reasonable classifications of these financially needy children, such as children in foster homes or private institutions for whom a public agency is assuming a full or partial financial responsibility.

In States electing to cover these financially needy foster children, there are children in foster care who cannot qualify for Medicaid because they have small incomes (from a Social Security child's benefit or other sources) in excess of the AFDC eligibility level for a family of one. The committee bill would allow States, at their option, to extend Medicaid coverage to children under 18 years of age (1) who reside in a foster home, group home, or private institution, (2) for whom a public agency assumes full or partial financial responsibility, and (3) whose income does not exceed 100 percent of the Federal poverty level. In determining eligibility under this option, States would not be allowed to apply a resource test, and would be allowed to use a methodology for determining income that is less restrictive than the methodology under their Title IV–E programs.

PART C—COMMUNITY AND FACILITY HABILITATION SERVICES AMENDMENTS

Over the last 20 years, dramatic advances have been made in the field of caring for individuals with mental retardation or a related condition such as cerebral palsy or epilepsy. Since 1971, when the Federal Government began paying for services to this population under Medicaid in institutions known as intermediate care facilities for the mentally retarded (ICF's/MR), changes in the philosophies of care and the technologies to implement them have led to a much wider range of long-term care options.

On September 30, 1988, the Subcommittee on Health and the Environment heard testimony regarding many people who had benefited from these advances, including the testimony of Sherilin Rowley of Utah, whose 9-year-old daughter has Down's Syndrome:

> My daughter Cydnee is now in an integrated classroom program in our neighborhood elementary school. This program allows her to participate in integrated programming through junior high and high school as well. . . .
>
> As part of her program, she has been hired by a librarian to water plants, to dust books, sort magazines by their dates, and replace returned books to the shelf in alphabetical order. One project was to sort all the National Geographics by date for the past 10 years. It didn't occur to the librarian that she might not be able to do it. She just expected her to do it, and she did.
>
> With the paycheck earned from this job, Cydnee can go out to lunch every Friday at the place of her choice as long as it is within her budget. Other skills connected with this job program are grocery shopping with a list and coupons, bus riding and street crossing.

> The ripple effect of this integrations that Cydnee is being invited to neighborhood birthday parties, to go ice skating with the entire school, and to go swimming at our neighborhood school. She also played on the community softball team this summer and also participated in other summer recreation programs.
>
> These wonderful effects are the result of mandates that Congress passed for the educating of infants, preschoolers and school-age students. How can we then as a Nation turn our backs on these students who have worked so hard to develop these skills that would allow them to become productive citizens? . . .
>
> Medicaid, as the rules now exist, does not assist her in her continued normal development. They don't allow her to remain in her own home with her own friends in her own community. After having worked with the professionals developing the skills, she needs to live as independent a life as possible. I find my only placement option if the Medicaid rules aren't changed is a State institution.

As illustrated by Ms. Rowley's testimony, States, with few exceptions, currently do not have the option of using Federal Medicaid funds to pay for health and health-related services to individuals with mental retardation or a related condition who are living in the community, either at home or in a non-institutional residential setting.

The major exception to the institutional ICF/MR benefit is the home and community-based services waiver under section 1915(c) of the Social Security Act. Under this authority, States may use Federal Medicaid funds to provide case management, personal care, habilitation, respite care, and other community-based services to individuals at risk of institutionalization. As of June 30, 1986, 33 States used this waiver authority to provide case management, personal care, habilitation, and respite care services to some 23,000 individuals with mental retardation or related conditions (*Medicaid Source Book,* p. 388).

In order to obtain a 1915(c) waiver, States must demonstrate to the Secretary that the average per capita expenditures for individuals participating in the waiver will not exceed the average per capita expenditures for those individuals in the absence of the waiver. As interpreted by the Secretary, this budget neutrality requirement has resulted in the imposition of caps on the number of individuals that can participate in a waiver. On September 30, 1988, the Subcommittee on Health and the Environment heard testimony from State Mental Retardation and Developmental Disabilities Agencies that the waiver authority, as administered by the Secretary, creates "powerful fiscal incentives" for the States "to limit waiver services to persons who are relatively expensive to serve in community settings rather than emphasizing low-cost services that are delivered to a wider segment of the potentially eligible service population."

The current benefits structure of the Medicaid program has led to an institutional bias in spending. In fiscal year 1986, total Federal and State Medicaid spending on services was $41.0 billion; of this

amount, $5.1 billion, or 12.4 percent, was spent on ICF/MR services. Total 1915(c) waiver expenditures that year for individuals with mental retardation and a related condition were $220.7 million, or ½ of 1 percent of total Medicaid spending. That same year, State-only, non-Medicaid spending for these individuals was $2.8 billion, with most of this amount spent on community services.

The committee bill has two major objectives. First, it would create parity between institutional and community services: Federal Medicaid matching funds would be available, at State option, for both services. As under current law, States would continue to have the option of using Federal Medicaid funds to purchase ICF/MR services for these individuals. In addition, the bill would establish a new optional Medicaid benefit, "community habilitation and supportive services," which States could elect to offer to individuals with mental retardation or a related condition in the community. Unlike the current 1915(c) waiver authority, States would not have to demonstrate budget neutrality to the Secretary, restrict the number of otherwise eligible individuals receiving such services, or limit such services to individuals at risk of institutionalization.

The bill's second major objective is to improve the quality of services paid for by Medicaid, in institutions or community settings, so as to promote the independence, productivity, and integration of individuals with mental retardation or a related condition. With respect to the current ICF/MR benefit, the bill would revise and codify current regulatory requirements for participation in Medicaid, restructure the survey and certification process, and expand State and Federal remedies for enforcing compliance with these requirements.

There is cause for concern about quality in both institutional and community settings. According to the Congressional Research Service, "testimony presented at Congressional hearings in 1985 showed that, despite the upgrading of conditions resulting from ICF/MR standards, abuse and neglect continue to be serious problems at some institutions" (*Medicaid Source Book,* p. 384). The recent revision of Federal ICF/MR regulations is one attempt to prevent such quality problems and assure that clients are receiving continuous active treatment.

In January of 1989, the Los Angeles Times published the results of an investigation of community services to this population in California. The investigation found a widespread pattern of "lethal neglect, physical and sexual abuse, and financial exploitation" of individuals with mental retardation living in privately run community settings throughout the State:

- From May to July, 1987, residents of a Behavior Research Institute Home in Orinda, California were beaten by a staff member who had a criminal record of arrests for attempted murder and convictions for burglaries, according to a complaint by State Department of Social Services attorneys seeking a revocation of BRI's license.
- A woman with mental retardation gave birth to a baby while in the bathroom of the Lois L. Jones Family Home in South-Central Los Angeles in January, 1986. The infant was drowned and left outside in a trash can, according to police and coro-

ners' reports. Licensing inspectors, seeking an emergency closure of the home, also said the memory of the proprietor was so impaired that she could not care for the residents.

- A 16-year-old autistic boy in the care of the Horizon House in Long Beach died Aug. 29, 1987, when staff members of the home allegedly delayed getting emergency treatment for the youngster after he began throwing up blood, according to State licensing reports.

(John Hurst, "Private Care for Retarded—A Gamble," Los Angeles Times, January 8, 1989)

From these articles, it is clear that State licensure programs can fail to protect the health and safety of clients, much less assure the provision of quality services. The committee is adamant that Federal Medicaid dollars are not used to finance the kinds of conditions identified by the *Los Angeles Times*. The committee bill would therefore require the Secretary to develop a set of interim minimum requirements concerning the health, safety and welfare and individual rights of clients receiving the new "community habilitation and supportive services" benefit. These requirements would apply to both the providers of services and the resident settings in which clients receiving such services live. Federal matching funds would not be available for the new benefit until 30 days after the Secretary has issued these interim requirements.

Subpart 1—Community Habilitation and Supportive Services

Sec. 4221—Community Habilitation and Supportive Services as an Optional, Statewide Service

Under current law, States are not eligible to receive Federal Medicaid matching funds for community-based services to individuals with mental retardation or a related condition, with a few limited exceptions. Under the section 1915(c) waiver authority, States may provide case management, personal care services, habilitation services, and respite care to individuals at risk of ICF/MR placement. States also have the option to offer case management services to particular groups in designated areas within the State. In addition, States have the option of providing personal care services as defined by the Secretary in regulation. Finally, some States have used certain optional service categories—clinic services and rehabilitation services—to offer day habilitation services to this population.

(a) *Provision as Optional, Statewide Service.* The committee bill would allow States, at their option, to cover under their Medicaid programs a new benefit, "community habilitation and supportive services." This benefit would be available on a statewide basis to all Medicaid-eligible individuals with mental retardation or a related condition. Unlike the 1915(c) waiver, this benefit would not be limited to individuals who are at risk of institutionalization, or to individuals who have been discharged from a nursing facility or ICF/MR (redesignated as "habilitation facilities"). Of course, Medicaid-eligible individuals who receive this benefit would also be would be entitled to whatever medical benefits (e.g., physician, hos-

pital, laboratory and x-ray, drug, etc.) the State offers generally under its Medicaid plan.

(b) *Definition of Community Habilitation and Supportive Services.* These are services designed to assist individuals with mental retardation or a related condition (1) in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to function successfully in a home or community-based setting, and (2) in participating in community or other activities. The State must provide certain "core" services: case management, respite care, and personal attendant care services. The State may also offer prevocational, education, supported employment, day habilitation and related services, transportation, assistive technologies or devices, and other supportive services.

With respect to the case management services, the committee bill specifies that they be delivered by entities independent of the providers of other community services to individuals with mental retardation or a related condition. The committee anticipates that case managers, whether agencies or individuals, will play an important role in assuring the quality of the services received by clients. To assure the effectiveness of the case managers, the committee bill requires that case management services be provided by entities that (1) do not provide community habilitation and supportive services other than case management, and (2) do not have a direct or indirect ownership or control interest in, or a direct or indirect affiliation or relationship with, a provider of other community habilitation and supportive services. An exception is made for such public entities as State agencies. The committee bill would not authorize case managers, whether public or private, to select the providers from which a client will receive services.

Federal matching funds are not available for (1) special education and related services otherwise available to the individual through a local education agency, (2) vocational rehabilitation services which otherwise are available to the individual, (3) room and board, and (4) payments made, directly or indirectly, to members of the family of the individual receiving community habilitation and supportive services. For this purpose, room and board is defined as non-personnel costs directly attributable to the purchase of food on behalf of clients, the cost of property, the purchase of household supplies not otherwise used in the provision of covered services, utility expenses, and the costs of facility maintenance, upkeep, and improvement (other than the costs of modifications or adaptations required to assure health and safety of residents or compliance with applicable life safety codes).

(c) *Individual with Mental Retardation or a Related Condition Defined.* Under current law, States have the option of offering ICF/MR services to "the mentally retarded or persons with related conditions." The Secretary has, by regulation, 42 C.F.R. 435.1009, defined "persons with related conditions" as individuals who have a severe, chronic disability that (1) is attributable to cerebral palsy or epilepsy, or to any other condition (other than mental illness) found to be closely related to mental retardation, (2) is manifested before the individual reaches age 22, (3) is likely to continue indefinitely, and (4) results in substantial functional limitations in three of more of the following areas of major life activity: self-care, un-

derstanding and use of language, learning, mobility, self-direction, and capacity for independent living.

Under the committee bill, individuals eligible for community habilitation and supportive services are individuals who (1) meet the State's Medicaid income and resource eligibility standards and (2) meet the categorical requirement that they are individuals with mental retardation or a related condition. The bill's definition of an individual with a related condition is identical to the Secretary's current regulatory definition of "persons with related conditions." Thus, the category of individuals eligible for community habilitation and supportive services under the committee bill is identical to the category of individuals eligible under current law for ICF/MR services. However, the bill does not require, and the committee does not intend, that individuals be at risk of institutional care in order to qualify for community habilitation or supportive services. In general, then, in a State which offers this new benefit, individuals with mental retardation or a related condition would be eligible (1) if they are receiving cash assistance under the Supplemental Security Income (SSI) program (except in a "209(b)" State which applies more restrictive income or resource standards), (2) if they qualify as a working, severely impaired individual under 1905(q) of the Social Security Act, or (3) if they "spend down" into eligibility as a "medically needy" individual in States electing to cover that group.

The committee recognizes that the bill's definition of "individual with mental retardation or a related condition" does not reach all individuals with developmental disabilities. The committee also recognizes that the Medicaid income and resource standards under this bill for individuals in the community are (as under current law) more restrictive than those for individuals in an institution; to this extent, the Medicaid program's institutional bias is likely to persist. The only exception is the eligibility policy under the 1915(c) home and community-based services waivers. Current law (and the committee bill) allows States to use the same special institutional income standard (up to 300 percent of the Supplemental Security Income benefit rate) for their waiver clients as they use (at their option) for their institutional population. Budgetary constraints precluded the committee from addressing these eligibility issues.

(d) *Maintenance of Effort.* Under the committee bill, if a State wishes to offer community habilitation and supportive services under its Medicaid program, it must report to the Secretary, in a format developed or approved by the Secretary, the amount of non-Federal funds obligated by the State (and its localities) for the provision of community habilitation and supportive services for individuals with mental retardation or a related condition during Federal fiscal year 1989. State (or local) expenditures for home and community-based services under a waiver under section 1915(c) of the Social Security Act need not be reported. The committee bill would not authorize the Secretary to require States to report State (or local) expenditures for (1) services to individuals with mental illness who are not individuals with mental retardation or a related condition, (2) vocational rehabilitation or special education services that are excluded from coverage as community habilitation

and supportive services, and (3) maternal and child health services that are not community habilitation and supportive services.

The committee stresses that a State which does not choose to offer this benefit is not required to file such a report. Nor does a State have to file a report at the close of fiscal year 1989 in order to keep open its option to cover these services. If a State did not elect to offer this benefit until, say fiscal year 1992, it would not have to file its report regarding expenditures during fiscal year 1989 until the beginning of the quarter in which the benefit was first offered.

In determining the amount of Federal Medicaid matching funds to be paid to a State for community habilitation and supportive services, the Secretary must reduce the total amount expended by a State (and its localities) for such services (other than under a 1915(c) waiver) by the amount of expenditures reported by the State (for itself and its localities) for fiscal year 1989.

The purpose of this requirement is to prevent States from using the option established by the committee bill to replace State (or local) dollars now being spent on community services for this population with Federal Medicaid dollars. In a discussion of this matter at a hearing before the Subcommittee on Health and the Environment on June 8, 1989, a letter dated June 5, 1989, from the California Department of Developmental Services was introduced into the record. In arguing that the cost estimates provided by the Congressional Budget Office were "unrealistically low," the letter stated: "California currently spends about $500 million each year from the State's General Fund for programs which we believe meet H.R. 854's definition of 'community habilitation services.' If California opted to include these services in its Medicaid State Plan, we project that the State could receive nearly $130 million in additional Medicaid reimbursements each year."

The maintenance of effort requirement in the committee bill would prevent such refinancing. Assume that a State (and its localities) spent $500 million on community habilitation and supportive services for individuals with mental retardation or related condition in fiscal year 1989 (excluding the amount it spent under a home and community-based services waiver for this population), and that the State in fiscal year 1991 elected to offer these services under the option established by the committee bill. In determining the amount of Federal Medicaid matching funds available to the State in connection with its fiscal year 1991 expenditures, the Secretary would first deduct $500 million from the total amount spent by the State (and its localities) on such services for this population in that year (excluding expenditures under a waiver), and would then apply the State's matching rate to any excess. Thus, if the State (and its localities) spent a total of $510 million in fiscal year 1991, and the State's matching rate was 50 percent, the State would receive $5 million in Federal Medicaid matching funds.

(f) *Effective Date.* The committee bill would be effective on the later of (1) July 1, 1990, or (2) 30 days after the date on which the Secretary publishes interim regulations to protect the health, safety, and welfare of clients receiving community habilitation and supportive services. The requirements in the committee bill would not apply to habilitation services furnished under a section 1915(c)

home and community-based services waiver in effect before July 1, 1990, until the date the next renewal of such a waiver takes effect.

(g) *No Abrogation of Freedom of Choice.* The committee bill specifies that this section shall not be construed by State or Federal agencies, or by the courts, to abrogate the right of Medicaid-eligible clients to freedom of choice with respect to the providers from whom they can receive covered services. Thus, if a State elects to offer both habilitation facility services and community habilitation and supportive services, then Medicaid-eligible individuals with mental retardation or a related condition who require the level of services in a habilitation facility would have the right to receive services in such a facility even if placement in a community setting would also be appropriate. The committee intends that the choice be that of the client, not the State.

Similarly, the committee bill does not authorize a State to restrict a client's choice of provider of community habilitation and supportive services. As under current law, clients would have the right to select from among the qualified providers who elect to participate in the Medicaid program. Although case management is a required element of any community habilitation and supportive services offered by a State, the case managers would not have any authority to designate providers for a client. In the view of the committee, freedom of choice of provider is fundamental to the goal of independence, through which clients exercise control and choice over their own lives.

Sec. 4222—Quality assurance for community habilitation and supportive services

Under current law, States providing home and community-based services covered under a 1915(c) waiver are required to provide assurances to the Secretary that necessary safeguards are in place to protect the health and welfare of beneficiaries. Failure to comply may result in termination of the waiver.

The committee bill contains a number of provisions that together are designed to assure the quality of community habilitation and supportive services. These services must be provided in a manner consistent with the objectives of expanding opportunities for independence, productivity, and integration into the community. They must be provided in accordance with an individual habilitation plan which is based on a comprehensive functional assessment. The Secretary is directed to develop minimum requirements to protect the health, welfare and safety of clients; these requirements would apply with respect to both the providers of community services and the residential settings where those services are provided. Procedures for monitoring and enforcing these minimum requirements would be established. In addition, States would be required to develop their own programs and standards for assuring the quality of these community services.

(b) *Independence, Productivity, and Integration.* Under the committee bill, the objectives of community habilitation and supportive services are to expand opportunities for independence, productivity and integration into the community. For this purpose, "independence" means the extent to which individuals with mental retardation or a related condition exert control and choice over their own

lives. "Productivity" means engagement by such an individual in income-producing work or work that contributes to a household or community. "Integration into the community" means the use of common facilities, participation in activities, and regular contact with residents (who are not individuals with mental retardation or a related condition) of the community where such individuals reside.

The committee notes that these principles of independence, productivity and integration into the community are basic goals for all habilitation services, whether offered in the community or in institutions. The committee bill, in section 4231, incorporates these same objectives into the quality of life requirement for habilitation facilities.

The quality assurance provisions in the committee bill apply with respect to community habilitation and supportive services provided under 1915(c) waivers, with the following exception. Waivers that were in effect before July 1, 1990, are exempt from these provisions until the later of (1) the date the next renewal of such a waiver takes effect, or (2) the end of the 30-day period after which the Secretary issues the interim requirements for minimum protections.

Under current law, Arizona is providing community-based services to individuals with mental retardation or a related condition under a section 1115 waiver. The committee bill provides that, effective July 1, 1990, the quality assurance provisions applicable to community habilitation and supportive services apply to Arizona under its section 1115 waiver program in the same manner as they apply to States that elect to cover these services.

(c) *Individual Habilitation Plans.* Community habilitation and supportive services must be designed and provided according to an individual habilitation plan (IHP), which specifies objectives to meet the client's needs, as identified in the comprehensive functional assessment. The IHP must also include a description of the client's medical care service needs, as identified by the client's physician. The IHP must be prepared by an appropriate interdisciplinary team and be periodically reviewed by this team after each comprehensive functional assessment (or periodic review of such assessment). In developing the IHP, the team must notify, provide for, and encourage the participation of the client, the client's parents (if the client is a minor), the client's legal guardian (if any), and the client's case manager. A parent of an adult client may not participate in developing the IHP if the client objects to that participation.

It is the committee's belief that a carefully developed IHP will assure proper attention to each person's unique strengths, needs, and circumstances, which will in turn promote quality services. The committee notes that, if an IHP identifies services community habilitation and supportive services needed by the client, and if those services are covered under the State's Medicaid plan, then the client is entitled to have payment made for those services. However, if the State Medicaid plan does not cover certain community habilitation and supportive services (e.g., transportation services), the client is not entitled to have payment made for those services.

(d) *Comprehensive Functional Assessment.* A comprehensive functional assessment must be prepared before the provision of community habilitation and supportive services to a client. The assessment must identify each client's developmental and behavioral abilities and management needs. The assessment must be conducted and periodically reviewed (at least annually) by an interdisciplinary team. In the case of a client with a seizure disorder, a professional with expertise in the diagnosis and treatment of such disorders must classify the disorder according to the most recent version of the International Classification of Epileptic Seizures. This professional need not necessarily be a member of the interdisciplinary team.

(e) *Minimum Requirements for Services.* Community habilitation and supportive services must meet minimum Federal requirements for the protection of health, safety, and welfare. These include: (1) minimum qualifications for personnel providing services; (2) guidelines for minimum compensation to assure the availability and continuity of qualified personnel to provide services to clients with various levels of impairment; and (3) requirements that providers protect and promote specified clients' rights.

The specified rights include: the right to be free from abuse or restraints (including involuntary seclusion); the right to privacy; the right to confidentiality of records; the right to be treated with dignity; the right to voice grievances without fear of reprisal; the right to choose the provider of community habilitation and supportive services; and any other right established by the Secretary.

In addition, the committee bill provides that psychopharmacologic drugs may be administered only (1) on the orders of a physician, (2) as an integral part of a plan (included in the IHP) designed to eliminate or modify the symptoms or behaviors for which the drugs are prescribed, and (3) if, at least annually, an independent, external, trained consultant reviews the appropriateness of the client's drug plan. It is the intent of the committee that psychopharmacologic drugs not be used in a manner that is inappropriate to the needs of the client or to manage clients for the convenience of providers.

With respect to the right to freedom from involuntary seclusion, the committee bill does not prohibit the use of "time-out" rooms for less than 1 hour, subject to review by the interdisciplinary team to ensure the use of the least restrictive and most positive behavior management intervention, and to ensure consistency with the IHP. The committee recognizes that there is disagreement in the field of mental retardation on the use of this approach, and stresses that it does not endorse the use of "time out" rooms as a standard practice.

(f) *Minimum Requirements for Residential Settings.* The committee bill establishes minimum requirements for residential settings in which one or more community habilitation or supportive services are provided, even though these residential settings are not themselves providers of services. (Residential settings that deliver and receive payment for services are subject to the minimum requirements applicable to providers). The purpose of these minimum requirements is to protect the health, safety, and welfare of clients receiving community habilitation and supportive services who

reside in such group homes, board and care facilities, and other residential settings. For this purpose, a residential setting does not include a setting, such as a client's home, in which fewer than 3 unrelated adults reside.

Under the committee bill, residential settings must: (1) meet the requirements relating to clients' rights, and administration and other matters, as they apply to habilitation facilities under section 4231, and (2) meet the requirements of the Life Safety Code of the National Fire Protection Association that are applicable and appropriate to the setting, subject to waiver by the Secretary under certain specified circumstances.

In addition, residential settings must disclose persons with ownership or control interests. Individuals may not have an ownership or control interest in a residential facility if they have been excluded from the Medicaid program, or if they have had an ownership or control interest in one or more residential settings that have been found to have repeatedly provided care of substandard quality.

The committee recognizes that, under this bill, the requirements for residential settings are not as stringent as for habilitation facilities. For example, habilitation facilities are required to provide continuous active treatment; residential settings are not. These differences in regulatory requirements may create an incentive for ICF's/MR to voluntarily decertify and convert to residential settings. The committee intends to protect clients in facilities undergoing such conversions from the loss of needed active treatment. The committee bill provides that, if part or all of a facility converts from a habilitation facility to a residential setting, the facility must continue to provide, or arrange for the provision of, continuous active treatment, to each client who was a resident at the time of conversion and who required active treatment at that time. The requirement applies so long as the client continues to reside in the setting and continues to require active treatment.

Finally, residential settings must document the medical care services received by a client in the client's clinical records. The setting is not itself required to provide or arrange for the provision of these services.

(g) *State Quality Assurance Program for Services.* Each State that elects to cover community habilitation and supportive services must establish and implement a program for assuring the quality of these services, and for protecting and promoting the rights of clients receiving these services. This quality assurance program must be consistent with the objectives of independence, productivity, and integration into the community.

A State quality assurance program must include the following elements, in a manner specified by the State:

(1) A State agency responsible for implementing the program.
(2) Publication of standards relating to the quality of services and to client's rights, consistent with the objectives of independence, productivity and integration into the community.
(3) A system of periodic monitoring (through onsite, unannounced reviews) of compliance with standards, of investigation of complaints, and of public disclosure of the results of

such monitoring and investigations. In the view of the committee, any effective quality assurance program should include an annual assessment of client satisfaction with community habilitation and supportive services, and regular public participation in the quality monitoring process.

(4) A system of enforcement of standards, including specified remedies.

(5) Public participation in the development of the quality assurance program. The committee expects that States will go beyond formal public hearings and comment periods to consult with and involve clients, parents, guardians, advocates and other interested citizens at every stage of development, implementation, and review of quality assurance programs.

(6) Programs to educate providers, clients, parents, and legal guardians about the quality assurance program. The committee intends that these education programs include training and continuing education of direct service staff in residential settings, and education and training programs for client, parent and advocate involvement in quality assurance programs.

A State's quality assurance program may also include incentives to reward providers of community habilitation and supportive services that deliver the highest quality care to clients under this title. These incentives may include public recognition or incentive payments, or both.

Under the committee bill, the Secretary has no authority to review or approve a State quality assurance program if the program, on its face, meets the stated requirements of this subsection. No Federal matching funds are available with respect to any expenditures, including any quality assurance incentives, made by a State in establishing or carrying out its quality assurance program.

(h) *Survey and certification.* The committee bill requires States to establish and implement a survey and certification process that the committee intends will assure compliance by providers and residential settings with the minimum requirements to protect to the health, safety, welfare and individual rights of clients receiving community habilitation and supportive services. Under this process, the State would be responsible for certifying, at least annually, the compliance of providers of community habilitation and supportive services, and of residential settings in which such services are provided, with the minimum requirements. In the case of providers or residential settings operated by the State, the Secretary would have this certification responsibility.

The committee bill provides for two certification methods. In the case of providers (other than residential settings that are providers), certification would be based on performance reviews rather than on-site surveys. In the case of residential settings (whether they are providers or settings in which services are provided), an unannounced on-site survey would have to be conducted at least once every 12 months. Surveys must be conducted on the basis of a protocol developed by the Secretary. To assure the adequacy of State surveys, the Secretary would be required to conduct "look behind" surveys in a sample of settings in each State using the

same protocols. Results of the surveys would be available to the public, State Protection and Advocacy Agencies, and State Medicaid Fraud Control Units.

In addition to their survey responsibilities, States would be required, through their survey agencies, to investigate allegations of client neglect and abuse by facility staff. Both the States and the Secretary would be required to maintain adequate staff to investigate complaints of violations of requirements by providers or residential settings. Where the Secretary has reason to question the compliance of a provider or setting, the committee bill authorizes the Secretary to make an independent survey or review.

The committee notes that these survey and certification requirements would apply to any State that offers community habilitation and supportive services, whether under the option established by the bill, or under a 1915(c) waiver that is subject to the requirements of the bill.

(i) *Enforcement Process.* The committee bill provides for a range of remedies for use by the States and the Secretary to enforce compliance with the minimum requirements. States would be required to establish the following remedies for noncompliance with the requirements by residential settings: (1) denial of payment for new clients; (2) civil money penalties; (3) appointment of temporary management; and (4) emergency authority to close a setting or transfer clients. With respect to providers of services that are not residential settings, civil money penalties would apply. The Secretary would be given independent authority to impose civil money penalties or, in the case of residential settings, to appoint temporary management. The committee expects that, as under current law, the Secretary's civil money penalty authority under this bill will be exercised by the Inspector General.

Where noncompliance immediately jeopardizes client health or safety, both the State and the Secretary would be required to take immediate action to remove the jeopardy and to correct the deficiencies through the appointment of temporary management, or to terminate Medicaid participation by the provider or residential setting. Where noncompliance does not immediately jeopardize client health or safety, both the State and the Secretary could apply any of the remedies available to them; however, in any case in which the Secretary did not impose a civil money penalty, the State would be required to impose civil money penalties for each day of noncompliance.

To assure prompt compliance with the minimum requirements, the committee bill requires States, in the case of a residential setting that has been out of compliance with any of the requirements for 3 months, to deny payment with respect to any clients admitted to the setting after notice to the public.

The costs incurred by States in implementing these remedies, including the costs of temporary management, are subject to Federal matching payments as necessary for the proper administration of the State plan.

The committee notes that, in establishing minimum "requirements" for providers and for residential settings, the bill does not use the regulatory framework of "conditions" and "standards" that currently applies to ICF/MR services. (Sections 4231–4233 of the

committee bill would modify the current law "conditions"/"standards" approach). It is the specific intent of the committee that, with respect to the provision of community habilitation and supportive services, and residential settings in which such services are provided, the Secretary assure compliance with each element of each minimum "requirement." The Secretary has no authority to redefine these "requirements" as "conditions" or "standards," or as "level A" and "level B" requirements.

(j) *Secretarial Responsibilities.* The committee bill directs the Secretary of HHS to publish, by July 1, 1990, an interim regulation that implements the minimum protections for the health, safety, and welfare of clients receiving community habilitation and supportive services. Under the bill, Federal Medicaid payments are not available for these services until 30 days after the publication of these interim regulations. The committee expects that the Secretary will make every effort to issue these interim regulations by July 1, 1990. To expedite the issuance of these regulations, the committee bill has not imposed any formal notice or public comment requirements on the Secretary (although the committee expects that the Secretary will consult with affected parties in the development of these regulations), and has waived the application of requirements under the Paperwork Reduction Act or Executive Order 12291.

These interim regulations must set forth the minimum requirements applicable to providers and residential settings, protocols for surveys of residential settings. The committee expects the Secretary, in developing survey protocols, to take into account the diversity of residential settings in which community habilitation and supportive services may be provided, and to devise protocols appropriate to this diversity. These interim regulations must also include the following minimum protections, which must be achieved through methods other than reliance on State licensure processes.

In order to avoid a repetition of the problems identified by the January 1989 *Los Angeles Times* investigation, these minimum protections must assure that (a) individuals receiving such services are protected from neglect, physical and sexual abuse, and financial exploitation; (b) providers and residential settings do not employ, contract with, or otherwise use individuals who have been convicted of child or client abuse, neglect, or mistreatment, or of a felony involving physical harm to an individual, and take all reasonable steps to determine whether applicants for employment have histories indicating involvement in such activities; (c) individuals or entities providing such services are not unjustly enriched as a result of abusive financial arrangements (such as owner lease-backs); and (d) individuals or entities delivering such services to clients, or relatives of such individuals, are not named as beneficiaries of life insurance policies purchased by (or on behalf of) clients.

The committee bill makes clear that the Secretary is not authorized to develop standards relating to the quality of community habilitation and supportive services beyond the scope of the minimum requirements for the protection of the health, safety, and welfare of clients.

The Secretary may not delegate the responsibility for developing interim or final regulations, or minimum requirements or protections, to the States.

The Secretary shall also make available to States, providers, clients and their representatives, technical assistance with respect to the assuring the quality of community habilitation and supportive services, including the development and operation of State quality assurance programs.

By no later than October 1, 1990, the Secretary must provide for the approval of training programs for State and Federal surveyors in conducting surveys for certifying residential settings where community habilitation and supportive services are provided with respect to the minimum Federal standards for health, safety, welfare and individual rights.

The committee bill requires that, no later than October 1, 1991, the Secretary issue final regulations implementing the minimum requirements to protect the health, safety, and welfare of clients. No Federal Medicaid matching payments may be made after October 1, 1991, for community habilitation and supportive services if the services, or the residential setting in which such services are provided, do not meet the minimum requirements.

Sec. 4223—Eliminating Prior Institutionalization Requirement Under Current Waiver Authority

Under the current 1915(c) home and community-based services waiver, States may, on a budget-neutral basis, provide habilitation services to individuals with mental retardation or a related condition in designated areas within the State, but only if those individuals have been discharged from a nursing facility or ICF/MR. Effective for waivers approved or renewed on or after enactment, the committee bill would delete the requirement that waiver beneficiaries must have been discharged from an institution in order to receive habilitation services.

Sec. 4224—Annual Report and Evaluation of Outcome-Oriented Instruments and Methods

(a) *Annual Report.* The Secretary would be required to report to the Congress annually on the extent of compliance with the minimum Federal requirements for community habilitation and supportive services, as well as the number and type of enforcement actions taken by States and the Secretary.

(b) *Evaluation of Outcome-Oriented Instruments and Methods.* The Secretary is required to study the effectiveness of existing outcome-oriented instruments and methods used to evaluate and assure the quality of community habilitation and supportive services, and report to the Congress, by no later than January 1, 1992, recommendations on the use of such instruments and methods (or the development of other instruments and methods).

Subpart 2—Quality Assurance for Habilitation Facility Services

Under current law, States have the option of offering services in an intermediate care facility for the mentally retarded (ICF/MR) to Medicaid-eligible persons with mental retardation or related condi-

tions. ICF's/MR are institutions (or distinct parts) which provide health or rehabilitative services, including "active treatment," to individuals with mental retardation or a related condition, and which meet standards prescribed by the Secretary. These standards, or conditions of participation, were recently revised for the first time since 1974 (53 *Fed. Reg.* 20448, June 3, 1988).

States are responsible for surveying and certifying compliance by ICF's/MR, whether private or State-operated, with the Federal conditions of participation. The Secretary has the authority to validate State survey findings through Federal "look behind" surveys. In the event that a survey finds noncompliance by an ICF/MR with the conditions of participation, only certain remedies are available to the Secretary. If the deficiencies pose an immediate threat to the health and safety of clients, the remedy is termination of all Medicaid payments to the facility. If the deficiencies do not pose an immediate threat to client health and safety, the Secretary may (1) allow the State to implement a correction plan under which all staffing and plant deficiencies are corrected within 6 months while the facility continues to receive Federal Medicaid matching funds; (2) allow the State to implement a reduction plan under which a facility permanently reduces the number of certified beds over a 3-year period while continuing to receive Federal Medicaid matching funds; or (3) terminate the facility's participation in the program.

Currently, 49 States cover ICF/MR services. As of June, 1986, States made Medicaid payments on behalf of 144,000 individuals with mental retardation or a related condition residing in more than 3,400 public and private ICF's/MR. These facilities ranged in size from 4 to 1,300 beds, with the State-operated facilities averaging 327 beds and the private facilities averaging 62 beds. In 1986, Federal and State Medicaid spending on ICF/MR services totalled $5.2 billion, an average of $36,100 per person. *Medicaid Source Book* at 380, 401.

The committee bill would retain the current ICF/MR benefit as a State option, renaming ICF's/MR as habilitation facilities. In order to assure the quality and appropriateness of facility services purchased with Federal Medicaid dollars, and to assure that clients in facilities (many of whom are medically fragile individuals with severe or profound retardation) are protected from abuse or neglect, the committee bill would make a number of changes, which would generally be effective January 1, 1991.

First, the committee bill would set forth, in statute, the requirements which habilitation facilities must meet in order to participate in the Medicaid program. Second, it would revise the current survey and certification system. Third, it would revise the current correction and reduction plan authorities and establish other intermediate sanctions for both the Secretary and the States. Fourth, it would replace the current utilization review procedures with a preadmission screening and annual review mechanism. Fifth, it would revise and clarify current rules for paying for facility services. Finally, it would require States to make fair and equitable arrangements to protect the interests of employees affected by the closure or reduction of habilitation facilities.

Sec. 4231—Requirements for Habilitation Facilities

(a) *Specification of Facility Requirements.* Under the committee bill, facilities currently described as intermediate care facilities for the mentally retarded (ICF's/MR) would be renamed "habilitation facilities." In order to qualify for Medicaid reimbursement, habilitation facilities would have to be engaged primarily in providing health or habilitation services to individuals with mental retardation or a related condition, and would have to meet requirements relating to the provision of services, clients' rights, and administration and other matters. These requirements would also apply in States like Arizona, which operate their Medicaid programs under a section 1115 waiver. As under current law, payment would not be made to facilities that are primarily for the care and treatment of mental diseases.

(b) *Provision of services.* An habilitation facility would be required to (1) maintain and enhance the quality of life, independence, productivity, and integration into the community of each client; (2) conduct a comprehensive functional assessment of each client promptly upon admission and review this assessment at least annually; (3) provide each client with continuous active treatment in accordance with an individual program plan (IPP) that is based on the functional assessment, and (4) provide professional program services needed to implement the active treatment plan defined in each client's IPP.

The committee bill retains the current law requirement that habilitation facilities provide continuous active treatment to each client in accordance with an IPP. The continuous active treatment must be coordinated and monitored by a qualified mental retardation professional. Active treatment is defined as services directed towards (1) the acquisition of behaviors and skills necessary for the client to function with as much self-determination, independence, productivity, and integration into the community as possible, and (2) the prevention or deceleration of regression or loss of current optimal functional status. Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, and health services. It does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

States have expressed concern about the scope and interpretation of the requirement of continuous active treatment. In the view of the committee, continuous active treatment should not be construed to require active programming for every client during every waking moment. On the other hand, the committee does not intend that Federal Medicaid funds be used to subsidize facilities that do not aggressively and consistently implement a program of training, treatment, and health services for their clients. To assure that State and private habilitation facilities know what is expected of them in this regard, the committee bill requires the Secretary to establish, by not later than January 1, 1991, an operational definition of continuous active treatment that (1) promotes a consistent assessment by State and Federal surveyors of whether a facility is in compliance and (2) clarifies the manner in which a program of

interventions and services is considered to be continuous. This operational definition need not be issued as a regulation; however, the committee expects that the Secretary, in developing this definition, will consult closely with State officials, clients, parents, facilities, direct care staff, advocates, and other interested parties.

In addition to active treatment, habilitation facilities are responsible for the provision of a broad range of health care services to clients. As under current law, the committee bill would require habilitation facilities to provide (or arrange for the provision of), through qualified personnel, the following health services: physician services, annual physical examinations, licensed nursing services, comprehensive dental diagnostic and treatment services, routine and emergency drugs and biologicals, and food and nutrition services that assure that each client receives at least 3 meals daily which meet the client's nutritional and special dietary needs. Medical, dental, and other services provided (or arranged by) an habilitation facility must meet professional standards of quality. All health care must be provided under the supervision of a physician.

With respect to staffing, the committee bill requires that habilitation facilities employ (or arrange for the provision of) sufficient direct care staff to meet the needs of clients at the facility. Facilities may not use a client or volunteers to meet this direct care staff requirement. While the committee bill would not quantify what a "sufficient" number of direct care staff would be in any given facility, the Secretary would have the authority to do so, and the committee does not intend to preclude in any way the kinds of staffing requirements that the Secretary has promulgated at 42 C.F.R. section 483.430(c)-(d).

To prevent abuse of clients, the committee bill would prohibit facilities from using individuals (in the capacity of direct care staff or otherwise) who have been convicted of child or client abuse, neglect, or mistreatment, or of a felony involving physical harm to an individual. The facility would be required to take all reasonable steps to determine whether applicants for any position at the facility have histories indicating involvement in child or client abuse, neglect, or mistreatment, or have a criminal record involving physical harm to an individual. If an applicant has such a history, the facility could not employ, contract with, or otherwise use the applicant.

The committee bill provides that psychopharmacologic drugs may be administered only (1) on the orders of a physician, (2) as an integral part of a plan (included in the client's IPP) designed to eliminate or modify the symptoms or behaviors for which the drugs are prescribed, and (3) if, at least annually, an independent, external, trained consultant reviews the appropriateness of the drug plan of each client receiving such drugs. The intent of the committee is the same with respect to habilitation facilities as it is in the context of community habilitation and supportive services: psychopharmacologic drugs must not be used in a manner that is inappropriate to the needs of the client or to manage clients for the convenience of facility staff.

(c) *Clients' Rights.* Habilitation facilities would be required to protect and promote certain specified rights of each client, including the (1) right to be free from abuse, (2) the right to be free from

restraints, (3) the right to privacy, (4) the right to confidentiality of records, (5) the right to accommodation of needs, (6) the right to be treated with dignity, (7) the right to voice grievances without the threat of reprisal, (8) the right to participation in client and family groups and other activities, (9) the right to examine survey results, (10) the right to choose a qualified mental retardation professional or case manager, (11) the right not to be compelled to perform services for the facility, and (12) any other right established by the Secretary. Facilities are required to inform each client, parent (if the client is a minor), or legal guardian, orally and in writing at the time of admission, of the client's legal rights.

The committee bill identifies the circumstances under which habilitation facilities may involuntarily transfer or discharge a client. A facility must permit each client to remain in the facility and must not transfer or discharge that client unless (1) the transfer of discharge is necessary to meet the client's welfare and the client's welfare can not be met in the facility; (2) the transfer or discharge is appropriate because the client no longer requires continuous active treatment; (3) the safety of individuals in the facility is endangered; (4) the health of individuals in the facility would otherwise be endangered; or (5) the facility ceases to operate, or the transfer or discharge is pursuant to a court order or under a reduction plan approved by the Secretary.

With respect to any transfer or discharge, the committee bill would require an habilitation facility to provide (1) a final summary of client's status and skills at the time of discharge, (2) recommendations relating to those service needs in the client's new living environment, and (3) sufficient preparation and orientation for the client to ensure safe and orderly transfer from the facility.

While the committee does not believe that clients who no longer require continuous active treatment should remain, at Medicaid expense, in an habilitation facility, the committee will not tolerate precipitous, poorly managed transfers or discharges that jeopardize fragile clients. The committee bill would prohibit habilitation facilities from transferring or discharging clients on the basis of the client's welfare (ground (1)) or the lack of need for active treatment (ground (2)) unless the client's new living environment has been identified and the service needs recommended by the facility in the client's new living environment will be met. The committee bill would prohibit facilities from transferring or discharging clients on the basis of danger to the safety (ground (3)) or health (ground (4)) of clients or staff in the facility unless adequate arrangements have been made for an alternative placement.

In the committee's view, one of the essential elements of a quality assurance system in institutional settings is ready access to clients. The committee bill would require habilitation facilities to permit access to clients by the client's immediate family or other relatives, the client's personal physician or qualified mental retardation professional, and representatives of the Secretary and the State. The committee bill would also specify the circumstances under which State protection and advocacy agencies would have access to clients or client records for the purpose of carrying out their responsibility to protect the legal and human rights of persons with developmental disabilities.

Under the committee bill, habilitation facilities would be required to establish and maintain identical policies and practices regarding (1) admission, transfer, and discharge, and (2) the provision of services covered under the State Medicaid plan, to all individuals regardless of source of payment. The purpose of this requirement is to prohibit facilities from discriminating against Medicaid beneficiaries by giving preference in admission or in the provision of services to private pay patients.

In order to protect clients and their families from financial exploitation, the committee bill would prohibit the following admissions practices: (1) requiring individuals to waive their rights to Medicaid coverage; (2) requiring a third party guarantee of payment as a condition of admission or continued stay; or (3) requesting any payments from an individual, his family, or others, as a condition of admission or continued stay in the facility. In addition, the committee bill would require facilities, upon written authorization by the client, to manage and account for the client's personal funds.

Administration and Other Matters. Under the committee bill, habilitation facilities would be required to meet criteria developed by the Secretary with respect to governing body and management, disaster preparedness, laboratory and radiological services, clinical records, and client and advocate participation. Facilities would have to be licensed under applicable State or local law, meet applicable Life Safety Code standards, maintain an infection control program, and comply with all applicable Federal, State, and local laws and regulations and with accepted professional standards and principles. In addition, habilitation facilities would have to meet other requirements relating to the health and safety of clients and the physical plant of facilities as the Secretary may prescribe. Life Safety Code standards would not apply to habilitation facilities in the following two circumstances: (1) the Secretary finds that specific provisions of the Code, if rigidly applied, would result in unreasonable hardship on a facility, and that waiver of those provisions would not adversely affect the health and safety of clients or personnel; or (2) the Secretary finds that the fire and safety code in a given State adequately protects clients of, and personnel in, habilitation facilities.

The committee bill clarifies that, as in the case of nursing facilities participating in Medicaid, the Secretary has the duty and responsibility to assure that requirements which govern the provision of care in habilitation facilities, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of clients. The committee intends that the ultimate responsibility for assuring the quality of services provided by habilitation facilities to Medicaid beneficiaries rest with the Secretary, and may not be delegated to the States.

These requirements would take effect with respect to habilitation facility services provided on or after January 1, 1991, without regard to whether implementing regulations have been promulgated. The committee bill makes clear that, prior to this date, nothing in the bill is to be construed to supersede the regulations issued by the Secretary on June 3, 1988, relating to conditions of participation for ICF's/MR.

Sec. 4232—Survey and Certification Process

In order to assure that habilitation facilities meet the requirements in this statute, the committee bill would revise the current survey and certification process. Under current law, States are responsible for surveying and certifying compliance by ICF's/MR with the conditions of participation. The Secretary has the authority to validate State survey findings through Federal "look behind" surveys.

Under the committee bill, compliance of habilitation facilities with Medicaid requirements would be certified through surveys. The surveys would be based on protocols developed, tested, and validated by the Secretary and would review (1) the quality, appropriateness, and effectiveness of active treatment provided at the facility, and (2) the facility's compliance with all of the requirements of participation. The review of active treatment provided at the facility would be based on a representative sample of clients and IPP's. Surveys would have to be conducted by a multidisciplinary team of professionals who meet minimum qualifications (including conflict of interest prohibitions) established by the Secretary and who have successfully completed a training and testing program approved by the Secretary.

To promote an accurate assessment of an habilitation facility's day-to-day compliance, the annual surveys would have to be conducted without prior notice to the facility. Any individual who notifies, directly or indirectly, a habilitation facility of the time or date on which a survey is scheduled to occur would be subject to a civil money penalty of up to $2,000. States would be required to take all reasonable steps to avoid giving notice of such surveys through scheduling procedures and conduct of the surveys themselves.

Surveys of habilitation facilities other than those operated by the State would be conducted by the State survey agency. In order to gauge the adequacy of the State surveys, the Secretary would be required to conduct on-site "look behind" surveys of a representative sample of facilities within 2 months of a State survey in a sufficient number to draw inferences about the adequacy of the State surveys. States found to have an inadequate survey and certification performance would be subject to a reduction in Federal matching payments for administrative costs. The committee bill would also give the Secretary independent authority to conduct a survey of any habilitation facility whenever there is a reason to question compliance.

Under the committee bill, surveys of State habilitation facilities are to be conducted by the Secretary, not by the States. The committee is concerned about current policy and practice, under which State survey and certification agencies review the performance of facilities operated by the State mental retardation agency in order to determine whether they should be certified to continue receiving payments from the State Medicaid agency (at rates that have been established by the State). In view of the large numbers of clients residing in State facilities, and the large amounts of Federal Medicaid funds being used to finance services for those clients, the committee believes that an independent Federal survey is the most effi-

cient and reliable method for certifying the compliance of State facilities with the requirements for participation.

The committee bill would require States, through their survey agencies, to investigate allegations of client neglect and abuse by facility staff. States would also be required to maintain adequate staff to investigate complaints of violations of requirements by habilitation facilities and to monitor, on-site, a facility's compliance. The results of surveys, including statements of deficiencies and plans of correction, would be available to the public, State Protection and Advocacy Agencies, and State Medicaid Fraud Control Units.

These revisions in the current survey and certification process would take effect January 1, 1991.

Sec. 4233—Enforcement Process

Under current law, if the Secretary, on the basis of a "look behind" survey, finds that an ICF/MR is out of compliance with the conditions of participation, the Secretary has the authority to terminate the facility's participation in the program. If the Secretary elects to terminate, he must notify the State agency and the facility, which is entitled to an administrative hearing and judicial review. If the Secretary finds that the facility's deficiencies do not present an immediate and serious threat to the health and safety of clients, and if the facility seeks an administrative hearing, Medicaid payments continue to be made to the facility until the hearing has been completed and a decision has been issued. If the Secretary finds that the facility's deficiencies present an immediate and serious threat to the health and safety of clients, and if the facility has been notified of its deficiencies and has failed to correct them, the Secretary must terminate the facility's participation in the program, and Medicaid payments do not continue pending a decision in the administrative hearing.

As an alternative to termination, current law gives the Secretary the authority, until January 1, 1990, to approve correction or reduction plans submitted by the States with respect to ICF's/MR that the Secretary has found, in a "look behind" survey, to have deficiencies that do not pose an immediate threat to the health and safety of residents. Under a correction plan, termination of a facility is postponed for up to 6 months to enable it to correct all staffing and physical plant deficiencies. Under a reduction plan, termination of a facility is postponed for up to 3 years to enable it to reduce its bed capacity or close altogether. During the period that correction or reduction plans are in effect, the deficient facilities continue to receive Medicaid payments.

In the view of the committee, the current enforcement remedies and procedures are not adequate to assure that clients and taxpayers are protected against the use of Federal Medicaid dollars to subsidize poor quality care in habilitation facilities. Neither the Secretary nor the States have a sufficient range of remedies to deter noncompliance, and facilities know that their financial exposure is minimal so long as they appeal the termination notice and clear up any deficiencies before their appeal comes to a hearing.

In 1987, the General Accounting Office (GAO) reviewed then-existing enforcement procedures with respect to nursing facilities.

The GAO found that "when deficiencies do not seriously threaten patient health or safety, there are no effective Federal sanctions to deter noncompliance. Even if the facility is repeatedly out of compliance, it will incur no penalty for not maintaining compliance." The GAO also found that "nursing homes know in advance that they will not be penalized if caught with serious deficiencies as long as they correct them sufficiently to qualify for recertification or stop ongoing decertification action." *Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed* (July, 1987). In response to the GAO recommendations, this committee, in the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203), revised the enforcement remedies and procedures applicable to nursing facilities participating in Medicaid

Although the GAO report concerned ICF's, not ICF's/MR, and although ICF's and ICF's/MR are different types of institutions serving different populations, the committee believes that the structural enforcement problems identified by GAO exist with regard to ICF's/MR. The committee bill would therefore revise current enforcement remedies and procedures in order to deter noncompliance with the requirements for participation, to deter repeat violations, and to terminate the participation of substandard facilities. In the view of the committee, there is no justification for continuing the payment of Federal Medicaid funds to a habilitation facility that does not meet the requirements of participation or that is not operating under an approved correction or reduction plan.

The committee notes that, in framing the requirements for habilitation facilities in section 4231, the committee bill does not use the current regulatory framework of "conditions" of participation. Under current practice, surveyors assess the compliance with a "standard." If a facility does not meet a majority of the "standards" in a "condition," the facility does not meet the "condition," and it therefore may not be certified for participation in Medicaid. Facilities that meet all of the "conditions" of participation, but are deficient in one or more "standards," may file a corrective plan of action for remedying the deficiencies over a 12 month period. During this period, the facility may continue to receive Medicaid payments.

The effect of this "conditions"/"standards" framework is to downgrade the importance of some critical performance criteria, giving facilities less of an incentive to comply. So long as a facility has an approved plan of correction, it has 12 months to bring itself back into compliance with any of the "standards" in which it was found deficient, and it is never exposed to any financial penalty for all the days it was deficient.

The current "conditions"/"standards" framework may be justified in a context where the only statutory remedy for noncompliance is termination. However, the committee does not believe it has merit where, as under the committee bill, both the Secretary and the States would have at their disposal a range of intermediate sanctions, including civil money penalties, to deter noncompliance. The committee bill therefore adopts a "requirements" of participation framework, under which a facility receiving Medicaid funds must at all times comply with all "requirements." Failure to meet one or more "requirements" would not necessarily result in termi-

nation (assuming no immediate jeopardy to client health or safety). However, it would subject a facility to the possibility of a civil money penalty or other intermediate sanction. The committee specifically intends that the Secretary discard the existing regulatory practices and conventions associated with the terms "conditions" and "standards," and develop a regulatory approach that clearly articulates and vigorously enforces the "requirements" for participation set forth in the committee bill.

The committee notes that, in the Secretary's recent regulations regarding requirements for nursing facilities, 54 *Fed. Reg.* 5316 (Feb. 2, 1989), "conditions" and "standards" were simply re-labelled "level A" and "level B" requirements. The committee stresses that this approach contravenes the plain language and the intent of the committee bill. Each of the "requirements" identified in the committee bill has equal weight with respect to whether a facility may be certified to participate in Medicaid and receive Federal matching funds. However, the specific sanction that is to be applied to remedy noncompliance will vary from "requirement" to "requirement." The committee bill would require both the States and the Secretary to specify criteria to be followed in imposing the remedies established by the bill, including criteria as to how the remedies are to be applied, the amounts of any fines, and the severity of each of the remedies. Repeated or uncorrected deficiencies would be subject to more severe fines. Thus, under the committee bill, each of the "requirements" would have equal compliance significance. However, because some "requirements" have greater bearing on the health and safety and active treatment of clients than do others, the committee expects that the sanctions for violating those "requirements" would be more severe than the sanctions for violating others.

The following example illustrates the difference. Under current regulations, 42 C.F.R. Part 483, client protections are a "condition" of participation which includes the following "standards": protection of client rights; client finances; communication with clients, parents, and guardians; and staff treatment of clients. Under the committee bill, facilities would have to meet "requirements" relating to clients' rights, including general rights, transfer and discharge rights, access and visitation rights, equal access to quality care, admissions policy, and management of client funds. While in substance many of the bill's "requirements" are similar or identical to the "standards" in the current regulation, the bill elevates them substantially in compliance priority for the facility. Under the current regulations, if a facility is deficient in, for example, the "standard" of protection of client rights because clients are not free from unnecessary drugs and physical restraints, but the facility meets all the other "standards" in the "condition" for client protections and meets all the other "conditions" of participation, the facility need only file a plan of correction and implement an approved plan over the next 12 months. The facility is not at risk of any financial penalty for noncompliance during this period. In contrast, under the committee bill, which requires an habilitation facility to protect and promote the right of a client to be free from any physical restraints or medications imposed for purposes of discipline or convenience of the staff, the facility would be subject to

the potential imposition of a civil money penalty or other intermediate sanction for each day during which it is found not in compliance with the "requirement." In this manner, the committee intends to deter noncompliance and repeated noncompliance, rather than merely correct it.

Under the committee bill, enforcement remedies and procedures would be established for both the States and the Secretary. States would be required to establish by statute or by regulation at least the following remedies: (1) denial of payment for new admissions; (2) civil money penalties, with interest, for each day a facility is or was out of compliance with a requirement of participation; (3) appointment of temporary management to oversee the operation of the facility and to assure the health and safety of clients; and (4) emergency authority to close the facility or transfer clients. These remedies would have to be in effect as of January 1, 1991.

In the case of facilities with deficiencies that immediately jeopardize the health or safety of clients, the committee bill requires that States either (1) take immediate action to remove the jeopardy and correct the deficiencies through the appointment of temporary management, or (2) terminate the facility's participation in the program. A State's reasonable expenditures for temporary management would be subject to Federal matching payments at the administrative matching rate of 50 percent. In the case of facilities with deficiencies that do not immediately jeopardize the health or safety of its clients, the committee bill allows the States to (1) impose one or more of the remedies described in the previous paragraph, (2) terminate the facility's participation in the program, or (3) do both.

To eliminate any incentive a facility might perceive not to bring itself into prompt compliance with all of the requirements of participation, the committee bill expressly authorizes (but does not require) States to impose civil money penalties, with interest, for each day in which a facility was not in compliance with one or more of the requirements of participation. In addition, if a facility has not complied with one or more of the requirements of participation within 3 months after the date it is found to be out of compliance, the committee bill would require the State to impose civil money penalties and to deny payment for all new admissions.

To deter repeated violations, the committee bill would require that, in the case of a facility found on 3 consecutive annual surveys not to provide continuous active treatment of adequate quality and effectiveness, the State must, in addition to any other remedies applied, (1) deny payment for new admissions, (2) impose civil money penalties for each day of noncompliance covered under the 3 annual surveys, and (3) monitor the facility until it has demonstrated that it is in compliance with all of the requirements of participation, and that it will remain in compliance with these requirements. The committee does not intend that this provision be construed to allow every noncomplying facility to have three "strikes" before being sanctioned. Instead, the committee's intent is to establish an absolute outer limit on the extent to which the program will tolerate noncompliance with the continuous active treatment requirement. The committee notes that remedy of termination is always available to the State (and the Secretary).

In the case of State habilitation facilities found out of compliance with a requirement of participation, the committee bill requires that the Secretary apply the remedies established in the law or regulations of that State, except that the Secretary would apply the Federal civil money penalties, not those of the State.

In addition to remedies, the committee bill would authorize States to establish programs to reward habilitation facilities that provide the highest quality services to clients. The rewards could take the form of public recognition, incentive payments, or both. The cost of any incentive payments or public recognition would be subject to Federal matching payments at the administrative rate of 50 percent.

With respect to the Secretary, the committee bill would authorize the following remedies: (1) denial of Federal matching payments to the State for payments to a facility after the effective date of a finding on behalf of new admissions or on behalf of all clients; (2) imposition of civil money penalties up to $10,000 for each day of noncompliance; (3) in consultation with the State, appointment of temporary management to oversee the operation of the facility and to assure the health and safety of its clients. It is the intent and expectation of the committee that the Secretary's civil money penalty authority will be administered by the Inspector General, who has the responsibility for administering identical civil money penalty authorities under current law.

In the case of facilities with deficiencies that immediately jeopardize the health or safety of their clients, the committee bill would require both the Secretary and the States to (1) take immediate action to remove the jeopardy and correct the deficiencies through temporary management, or (2) terminate the facility's participation in Medicaid. The bill also authorizes both the Secretary and the States to impose additional sanctions in this circumstance, including civil money penalties.

In the case of facilities with deficiencies that do not immediately jeopardize the health and safety of clients, both the Secretary and the States would be authorized to impose any of the remedies established under the committee bill, or any other remedies they may have under other sources of law. In addition, as an alternative to decertification, the committee bill would authorize the continuation of Federal Medicaid matching funds for services delivered by the facility that is not in compliance with one or more of the requirements of participation, but only under the terms of a plan of correction or a reduction plan approved by the Secretary. The Secretary would have no other authority for continuing payments to noncomplying facilities.

Under a plan of correction, a facility would have up to 6 months from the effective date of the finding of deficiencies to bring itself back into compliance with all of the requirements of participation. The plan would have to be approved by the Secretary, upon request of the State. If the corrective action is not taken in accordance with the approved plan and timetable, the State would be required to repay the Federal Government any matching payments received for services provided by the facility during the period of noncompliance. The committee expects that the Secretary, in establishing guidelines for the approval of corrective action plans, will limit to

30 days from receipt of a State request the time allowed to the Department for review and approval of correction plans.

Under a reduction plan, States could continue to receive Federal Medicaid matching payments for up to 36 months from the effective date of the findings of deficiencies for services provided by a noncomplying facility. The reduction plan would require (1) the permanent reduction in the number of certified beds as the facility so as to eliminate the facility's deficiencies, and (2) the provision of services to clients at the facility who will not continue to receive services at the facility after the reduction in bed capacity, including community services. The committee notes that a State could provide these services through a 1915(c) waiver, through the new optional benefit established under section 4221 of the bill, or through programs and services paid for by the State, localities, or private sources.

In order to approve a State's request for a reduction plan, the Secretary must find that the State (1) has provided for a public hearing on the plan at the affected facility at least 30 days before submission of the plan to the Secretary, (2) has successfully provided community services to clients other than those who would be affected by the reduction, and (3) will make fair and equitable arrangements to protect the interests of affected employees under section 4247 of the committee bill.

In addition, in order to approve the reduction plan the Secretary must find that the plan itself meets the following requirements. First, the plan must (1) identify the clients who will be displaced by the reduction, (2) describe each client's needs for services and provide a timetable for providing such services, (3) provide for continuous active treatment for such clients after discharge under their IPP's, (4) identify the safeguards to protect the health and welfare of such clients upon discharge, including standards to assure quality of the services they will receive in the community, and (5) prepare and orient clients to facilitate either a safe and orderly transfer to another habilitation facility or integration into the community. Each Medicaid-eligible client must be given the option of remaining a client at the facility or being transferred to another habilitation facility at which the client may continue receiving Medicaid-funded services. Finally, the plan must specify the actions to be taken to protect the clients who remain at the facility while the reduction plan is in effect. These actions would at a minimum include maintenance of ratios of qualified staff to clients adequate to protect the health and safety of, and to provide for the continuous active treatment under the clients' IPP's.

The committee bill would require the Secretary to review compliance with the provisions of approved reduction plans at 6-month intervals. If the Secretary finds that the requirements of the plan are not being met, or that the State is not complying with the employee protection requirements, the bill would require the Secretary either (1) to terminate the facility's participation in the program or (2) to disallow, for each month of noncompliance, 5 percent of the Federal Medicaid matching payments which would otherwise be made for services provided at the facility. If the Secretary finds that the facility has not maintained adequate staffing ratios for the remaining clients, the bill would require the Secretary to disallow

all Federal matching payments for each month that the facility fails to maintain adequate ratios.

The committee bill would revise the current reduction plan authority to enable a State to seek a reduction plan not only on the basis of findings made by the Secretary in a "look behind" survey, but also on the basis of findings made by a State survey agency on or after May 1, 1989. As under current law, the current reduction plan authority would be repealed effective January 1, 1990, but correction or reduction plans approved before the date of enactment would continue to operate under their terms and conditions. With respect to the Los Lunas Hospital and Training School in Los Lunas, New Mexico, the State would have 30 days after enactment to file a correction plan, and 65 days after enactment to file a reduction plan, for approval by the Secretary under the requirements of the current law correction and reduction plan authorities.

Sec. 4234—Effective Dates

The new requirements of participation (section 4231) and the revised survey and certification procedures (section 4232) would be effective January 1, 1991, without regard to whether implementing regulations have been promulgated. The enforcement provisions relating to the Secretary's authority would be effective on enactment, without regard to whether implementing regulations have been promulgated. The Secretary's new enforcement authority would apply to existing ICF's/MR, but only with respect to findings of noncompliance made after the date of enactment. The repeal of the current correction and reduction plan authority would be effective July 1, 1990, but would not apply to plans approved before the date of enactment.

Sec. 4235—Annual Report

The Secretary of HHS would be required to report annually to Congress on the extent of compliance by habilitation facilities and the number of enforcement actions taken.

Subpart 3—Appropriate Placement for Individuals With Mental Retardation or a Related Condition

Sec. 4241—State Preadmission Screening and Annual Client Review

Under current law, States must have in effect a preadmission screening program to determine (1) whether individuals with mental retardation or a related condition who seek admission to general nursing facilities require the level of services provided by a nursing facility and (2) whether they require active treatment. States are also required to review, on an annual basis, each nursing facility resident with mental retardation or a related condition to determine (1) whether the individual requires the level of services provided by the nursing facility and (2) whether the individual requires active treatment.

These preadmission screening and annual review requirements do not apply to ICF's/MR. Instead, a physician (or physician assistant or nurse practitioner) must certify, at the time of admission and at least every 12 months thereafter, that an individual needs ICF/MR services. In addition, an interdisciplinary team of health

professionals must make a comprehensive medical, social, and psychological evaluation of the need for care prior to admission or authorization for payment.

The current preadmission screening and annual review requirements have three basic purposes: (1) to prevent the inappropriate placement (or continued stay) of individuals with mental retardation or related condition in institutions, (2) to identify the service needs of these individuals, and (3) to preclude the use of Federal Medicaid funds for unnecessary institutional care. In the view of the committee, these purposes are equally compelling in the context of habilitation facility services. The committee bill would therefore require that States implement a similar program with respect to habilitation facilities.

Under the bill, States would be required to establish a preadmission screening program for all individuals with mental retardation or a related condition who are admitted to habilitation facilities on or after January 1, 1991. Habilitation facilities would be prohibited from admitting individuals determined not to require the level of services provided by a facility. In addition, States would have to conduct annual reviews of each client in a habilitation facility; all clients residing in such facilities who had not been subject to a preadmission review would have to be reviewed by January 1, 1992. These requirements would be delayed with respect to private pay individuals until the individual becomes eligible for Medicaid. States would be responsible for implementing these requirements whether or not the Secretary issues final implementing regulations.

With respect to preadmission screening, the State mental retardation or developmental disability authority must determine, prior to admission, whether the individual requires the level of services provided by an habilitation facility. This determination must be based upon an independent evaluation performed by a person or entity other than a habilitation facility, and must be based upon Federal minimum criteria developed by the Secretary. States must have in effect an appeals process that meets minimum criteria specified by the Secretary to permit individuals who are adversely affected to obtain an impartial review of the determination.

The committee emphasizes that the preadmission screening determination affects only an individual's eligibility for habilitation facility services. It does not, and is not intended to, restrict an individual's eligibility for whatever community habilitation and supportive services a State may choose to offer, or for any medical or other health services that a State covers under its Medicaid plan.

With respect to annual reviews, the committee bill would require the State mental retardation or developmental disability authority to conduct a review, at least annually, of (1) whether a client requires the level of services provided by a habilitation facility and (2) whether a client requires community habilitation and supportive services. The review must be based on an independent evaluation performed on site by a person or entity other than the facility, using minimum criteria developed by the Secretary. The evaluation must take into account the client's comprehensive functional assessment. States must have in effect an appeals process that meets minimum criteria specified by the Secretary to permit individuals

who are adversely affected to obtain an impartial review of the evaluation.

In the case of clients found not to require the level of services provided by the facility but to require community habilitation and supportive services, the committee bill would require the State, in consultation with the client's family or legal representative and care-givers, to (1) arrange for the client's safe and orderly discharge, (2) prepare and orient the client for discharge, and (3) provide for (or arrange for the provision of) the required community habilitation and supportive services. To assure these discharges are well-managed managed and do not harm the client, the committee bill specifies that they be consistent with the client's transfer and discharge rights under the bill, including the requirement that the service needs of the client will be met in the client's new living environment. The State could meet the bill's requirement that it provide for (or arrange for the provision of) the required community habilitation and supportive services through a 1915(c) waiver, through the new optional benefit authorized by section 4221 of the committee bill, or through programs and services funded by the State, by localities, or by private sources.

In the case of clients found not to require either the level of services provided by an habilitation facility or community habilitation and supportive services, the State would be required to (1) arrange for the client's safe and orderly discharge (consistent with the client's transfer and discharge rights) and (2) prepare and orient the client for discharge.

The committee bill would not require the Secretary to use a formal rulemaking process, with proposed and final regulations, in developing the minimum criteria for preadmission screening and annual review determinations. However, the committee expects that the Secretary, in developing these criteria, will consult with the States, parents' groups, and advocates.

Sec. 4242—Revision of Utilization Review Provisions

Under current law, States must obtain the certification of a physician, at the time of admission and periodically thereafter, that an individual needs ICF/MR services. In addition, an interdisciplinary team of health professionals must make a comprehensive medical, social, and psychological evaluation of the need for care prior to admission or authorization for payment. Finally, each resident of an ICF/MR is subject to an annual onsite inspection of care by an independent professional review team (composed of a physician or nurse and other appropriate personnel) to determine (1) the adequacy of available services, (2) the necessity and desirability of continued placement in the facility, and (3) the feasibility of meeting the individual's health care needs through alternative institutional or noninstitutional services. States that do not meet the physician recertification or inspection of care requirements with respect to ICF/MR clients are subject to reductions in Federal matching funds for ICF/MR services according to a statutory formula.

To eliminate unnecessary duplication, the committee bill would repeal the existing requirements relating to utilization review, including physician certification and recertification, and inspection of care, as they apply to habilitation facilities. The repeal would take

effect when the Secretary determines that a State has begun conducting annual reviews of clients under section 4241 of the bill.

Subpart 4—Payment for Community Habilitation and Supportive Services and Habilitation Facility Services

Sec. 4244—Payment for Services

(a) *Reasonable and Adequate Payments.* Under current law, States electing to offer ICF/MR services have discretion in establishing payment methodologies and rates. Payments for ICF/MR services (as for other services) must be consistent with efficiency, economy, and quality of care, and must be sufficient to induce enough providers to participate in the program that services are available to beneficiaries at least to extent that those services are available to the general population. These same rules apply to with respect to personal care services, habilitation services offered under 1915(c) waivers, as well as day habilitation services offered as optional clinic or rehabilitation services.

With respect to institutional services, the Secretary has, by regulation, limited aggregate Medicaid payments for (1) ICF/MR services in each State and (2) services provided by State-operated ICFs/MR in each State, to the estimated amount that would have been paid under Medicare reimbursement principles.

A review by the Congressional Research Service of State reimbursement methodologies for fiscal year 1987 found that 35 States paid for ICF/MR services on a prospective basis, 13 paid on a cost basis, and 1 paid State-operated facilities on a cost basis and private facilities on a prospective basis (2 States did not cover ICF/MR services). CRS noted that, in the case of ICF/MR services, the distinction between prospective and cost systems "may not always be meaningful. Prospective rates may be set at a level sufficient to meet the facility's full anticipated costs. Most ICF/MR services are furnished in State facilities. If the State's Medicaid reimbursement to these facilities is less than their full operating cost, the State will have achieved Medicaid savings only at the expense of another part of the State budget." (*Medicaid Source Book,* pages 131–133).

In the view of the committee, one of the key determinants of the quality of care is the amount of payment a provider is receiving for services rendered. The committee recognizes that reimbursement levels are not the only factor affecting quality. But the provision of quality care, whether in an institutional or community setting, requires resources. If payment rates are set too low, it will be extremely difficult for a provider to deliver services of adequate quality without using excess funds received from other payors, or drawing upon any endowment or operating surplus. Of course, this cross-subsidization is not feasible for providers that do not have endowments or surpluses, or that serve primarily or exclusively Medicaid clients.

Under the committee bill, States would be required to pay for habilitation facility services through rates which are reasonable and adequate to meet the costs which be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. States are allowed to estab-

lish their own methodologies, but those methodologies must not distinguish between State-operated providers and other providers. Thus, if a State's payment methodology applies an inflation index or a cost limit to a private facility, the same index or limit would have to be applied, in the same manner, to the State facilities. The committee bill does not require that the State pay identical rates to private facilities and State facilities.

The adequacy of Medicaid payment rates is a particular concern in community settings, where low wages and limited benefits can result in high staff turnover that severely compromises the quality and continuity of care available to clients. The Subcommittee on Health and Environment heard testimony from one non-profit community provider that "Our budget is $11 million a year, of which I must raise $3.5 million to keep our doors open. That's supplementing the gap between government funding and actual cost. Incidentally, my direct care staff make $4.25 an hour, and that's not by choice. That's because of the rates we get." It is difficult to minimize staff turnover if Medicaid reimbursement rates do not allow providers to pay their direct care staff more than—or even as much as—these individuals could earn in a fast-food restaurant.

Under the committee bill, States that elect to offer community habilitation and supportive services must pay rates which are reasonable and adequate to meet the costs of providing services, efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards. These laws and regulations include the guidelines promulgated by the Secretary regarding minimum compensation to assure the availability and continuity of qualified personnel to provide services to clients at various levels of impairment. If payment rates do not meet these requirements, Federal Medicaid matching funds would not be available for community habilitation and supportive services.

The committee bill does not require States to use a specific methodology in setting payment rates for providers of community habilitation and supportive services. Whatever methodology a State chooses to use, however, must not distinguish between State-operated providers and other providers. States are not required to set identical payment rates for public and private providers.

With respect to both community and facility services, the committee bill would prohibit States from paying on a capitation or other risk-based basis. The committee is concerned that risk-based reimbursement, under which providers have an incentive not to deliver services, may not be consistent with the delivery of quality care to such a vulnerable population.

These provisions are effective with respect to community habilitation and supportive services delivered on or after the later of July 1, 1990, or 30 days after publication of interim regulations regarding minimum protections. For habilitation facilities, these provisions apply to services furnished on or after January 1, 1991.

(b) *Denial of Federal Payments to Compensate for Civil Money Penalties.* The committee bill provides that Federal Medicaid matching funds would not be available for reimbursing the costs of any civil money penalties imposed on either providers of community services or habilitation facilities. Federal Medicaid funds are

available for covered services delivered in compliance with program requirements, not for sanctions imposed to remedy noncompliance.

Subpart 5—Employee Protections and Miscellaneous

Sec. 4247—Employee Protections

Under current law, the Secretary may not approve an ICF/MR reduction plan unless the plan provides for the protection of the interests of affected employees. These protections must include arrangements to preserve employee rights and benefits, training and retraining of affected employees where necessary, redeployment of affected employees to community settings, and maximum efforts to guarantee the employment of such employees.

Over the past two decades, a number of States have moved to reduce the number of residents in large State-operated ICF's/MR. Between 1967 and 1987, the number of individuals with mental retardation in large public facilities declined from 194,650 to 94,565 (*Medicaid Source Book,* p. 378). Deinstitutionalization affects not only the residents, but also the employees at the facilities involved. The Subcommittee on Health and the Environment heard testimony that in 14 States, about 12,000 State employees who have been displaced from State-run institutions have continued to deliver services to individuals with mental retardation, either in other institutions, or in community settings, maintaining their State employee status. In some of these States, workers have been redeployed from large State-run institutions to small State-run community settings; in New York alone, some 8,600 State workers have been redeployed since 1975 into over 400 community settings.

The committee bill would require States to provide that specified fair and equitable arrangements have been made to protect the interests of habilitation facility employees who are affected by a closure or reduction in capacity at that facility. This requirement applies whether or not the closure or reduction in capacity is pursuant to a reduction plan under section 1928(i), and it applies whether or not the facility subject to closure or reduction is operated by the State.

In protecting the interests of affected employees, the State must ensure that the following arrangements have been made:

(1) rights, privileges, and benefits (including continuation of pension rights and benefits) under applicable collective bargaining agreements must be preserved;
(2) collective bargaining rights through any certified representative must be continued;
(3) individual employees must be protected against a worsening of their positions with respect to their employment at the facility during the period of the closure or reduction;
(4) employment of affected employees with at least the same compensation (including benefits) and a comparable level of job responsibilities must be assured, except that this shall not be construed as entitling an affected employee to lifetime employment or as protecting an employee against a discharge for good cause;

(5) paid training or retraining programs must be established for the employment of affected employees in the provision of community services to individuals with mental retardation or a related condition (whether or not the State has opted, under section 4221 of the committee bill, to offer community habilitation and supportive services); and
(6) a specified grievance procedure must be provided for affected employees to assure the preceding requirements have been met with respect to such employees.

With respect to requirement (4), in the case of a State-operated facility, the State must offer to affected workers employment, with at least the same compensation (including benefits) and a comparable level of job responsibilities, with a provider of community-based services to individuals with mental retardation, or in a residential setting in which such services are provided. In order to comply with this requirement, a State need not operate the community provider or residential setting; it could, at its option, make arrangements for the placement of affected State employees (with at least the same compensation, including benefits, and a comparable level of job responsibilities) at privately operated providers or settings. The committee does not intend to require a State which closes or reduces one of its facilities to offer the optional community habilitation and supportive services benefit under section 4221 of the committee bill. If the affected employee in these circumstances declines the State's offer of employment with a community provider or residential setting, the State, in order to meet requirement (4), may offer the employee a position (with the same compensation, including benefits, and a comparable level of job responsibilities) at another habilitation facility or at another State agency.

With respect to requirement (5), the committee bill provides that Federal Medicaid matching funds are available at the rate of 50 percent for the reasonable expenses associated with the training and retraining programs for employees affected by the closure or reduction of habilitation facility employees. The committee intends that the Secretary allow all reasonable costs which the State incurs in training or retraining affected employees to provide quality community habilitation and supportive services. Federal financial participation would not be available for the costs of training or retraining for skills that are not used in connection with the delivery of community habilitation and supportive services.

With respect to requirement (6) for a grievance procedure, the committee bill provides for two options. First, the bill outlines a procedure that includes a 60-day informal resolution period, the option of the employee to either binding arbitration or a hearing within 45 days of request, and a decision within 30 days of the hearing or arbitration. Second, in the case of affected employees with certified bargaining representatives, if the State and the representative agree, the parties may use a procedure other than that specified in the bill. The costs of the arbitration proceeding are to be divided evenly between the affected employee and the State; the cost of the hearing are to be borne solely by the State. Federal Medicaid matching funds are not available for the costs of arbitration proceedings, hearings, or alternative grievance procedures.

The requirements in the committee bill that States make fair and equitable arrangements to protect the interests of affected employees shall not be construed as superseding or abrogating any collective bargaining agreement or any statutory or contractual labor/management negotiating process to the extent that such agreement or process contains protections for individual employees that comply with the requirements of the committee bill.

These requirements are effective on enactment, regardless of whether the Secretary has issued final regulations to implement these provisions.

Sec. 4248—Use of State Developmental Disabilities Agency

Under current law, a single State agency designated by the State administers the Medicaid program. Under the committee bill, States would be allowed to assign to the State developmental disabilities agency specific Medicaid program management functions relating to the provision of services to individuals with mental retardation or a related condition. Federal Medicaid matching funds would be available, at the rate of 50 percent, for the reasonable administrative expenses of the State developmental disabilities agency in carrying out such assigned functions (other than the costs of a State quality assurance program for community habilitation and supportive services under section 1927(g)) in the same manner as they are available for similar expenses of the single State agency.

PART D—FRAIL ELDERLY COMMUNITY CARE AMENDMENTS

Sec. 4251—Community Care As Optional, Statewide Service

Under current law, States use Federal Medicaid matching funds to purchase nursing home care on behalf of low-income elderly in skilled nursing facilities (SNF's) and intermediate care facilities (ICF's). Payments for SNF and ICF services account for approximately 30 percent of all Medicaid spending.

Coverage of non-institutional long-term care services is far more limited. States are required to provide home health services (including part-time nursing, home health aide, and medical supplies and equipment) to individuals entitled to SNF care. About 3 percent of all Medicaid spending goes toward this service. (*Medicaid Source Book,* p. 35). In addition, the States have the option of covering personal care services, as well as case management services targeted on specific population groups.

There are other services that enable frail elderly who need long-term care to remain in the community, including chore services, respite care, and adult day health. However, Federal Medicaid matching funds are currently available for these non-medical services only under the 1915(c) home and community-based services waiver. Under this authority, States are allowed to provide a range of home and community-based services to individuals who are at risk of institutionalization. However, in order to obtain Federal Medicaid matching funds for these services, a State must demonstrate to the Secretary that the average per capita Medicaid expenditure for services to individuals under the waiver will not exceed the average per capita Medicaid expenditure for services to

those individuals in the absence of the waiver. States may target waivers on specific groups (e.g., aged, disabled children, individuals with mental retardation) in specific areas of the State, and may limit the number of otherwise eligible individuals who may enroll. As of February, 1988, 36 States were operating one or more 1915(c) waivers targeted at the aged and disabled (*Medicaid Source Book,* p. 160).

The budget neutrality requirement in the 1915(c) waiver has proven to be a major impediment to State efforts to provide home and community-based services to the low-income frail elderly. Since the enactment of the waiver authority in 1981, the Subcommittee on Health and the Environment has closely monitored the implementation of the waiver. As a result of concerns expressed by State officials, most notably at a major hearing on this issue held by the subcommittee on June 25, 1985, the subcommittee reported a number of revisions in the waiver authority that were enacted in 1986 (section 9502 of COBRA, Public Law 99–272, and section 9411 of OBRA 1986, Public Law 99–509). Despite these and subsequent changes, the budget neutrality requirement remains a major barrier to expansion of home and community-based services. As one State official testified at a hearing before the subcommittee on June 8, 1989, "HCFA forces our State as well as others which have such waivers through a series of hoops expressly designed to discourage all but the most persistent."

In the view of the committee, the time has arrived to give the States the option of using Federal Medicaid funds to match State payments for home and community-based services to the frail elderly without demonstrating budget neutrality to the Federal Government. Accordingly, the committee bill would establish a new optional Medicaid benefit, community care services for functionally disabled elderly individuals. The types of services that a State could offer under this option would be essentially the same as those which a State can now provide under the 1915(c) waiver; however, States would not have to demonstrate budget neutrality as they must under the waiver. To limit expenditures, though, States would be subject to a maintenance of effort requirement and an aggregate ceiling on payment amounts. The bill would retain the current 1915(c) waiver authority, so that States would have the choice of using either the community care benefit or the waiver, or both, or neither.

The committee stresses that this bill represents a modest, incremental improvement in long-term care coverage for the low-income frail elderly. The benefit is optional, not mandatory. The class of potential beneficiaries is sharply constrained by the bill's definition of functional disability. In addition, beneficiaries would have to meet existing income and resource standards for Medicaid eligibility in the community; these standards are substantially more restrictive than those for either institutionalized individuals or than those for individuals participating in the 1915(c) waivers. To prevent the States from substituting Federal Medicaid funds for State community care dollars, the bill would impose a strict maintenance of effort requirement. Moreover, the bill would limit aggregate payments for these services to an aggregate payment ceiling defined by 30 percent of the rate for Medicare SNF services in the State. In

short, the committee, in framing this new optional benefit, has employed every reasonable cost constraint available to it.

The committee recognizes that quality is of major concern in the provision of community care services to the frail elderly. The magnitude of the problem was underscored by a February, 1989, General Accounting Office report on board and care facilities, where many potential beneficiaries of community care services reside. Reviewing the records of board and care facilities in 6 States, GAO found that, even though these facilities were licensed by the States, problems persisted year after year, ranging from "very serious situations in which residents have been subjected to physical and sexual abuse, to problems involving persistent insanitary conditions, such as improperly stored food and trash. In some cases board and care residents had been denied heat, were suffering from dehydration, were denied adequate medical care, or had food withheld if they did not work. Situations have also occurred that have contributed to the death of board and care residents. . . . [These] problems are concentrated in homes with low-income residents, especially those living on SSI" (*Board and Care: Insufficient Assurances That Residents' Needs Are Identified and Met,* GAO/HRD-89-50).

The committee bill contains a number of safeguards designed to assure that Federal Medicaid funds do not pay for substandard quality care in either a board and care facility or in any other residential settings. Rather than place beneficiaries at risk of the problems documented by GAO, the committee bill place major responsibility for assuring the quality of community care on the case manager and the beneficiary. In addition, the bill would direct the Secretary to develop minimum requirements for community care and minimum requirements for the residential settings in which community care is provided. These minimum requirements would include protections from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of services by unqualified personnel. Compliance with these requirements would be monitored by unannounced State surveys using protocols developed by the Secretary. To assure that Federal Medicaid matching funds do not at any point finance substandard quality services, the committee bill would limit the availability of these funds for community care services until the later of July 1, 1990, or 30 days after the issuance of interim minimum requirements by the Secretary.

(a) *Provision as Optional, Statewide Service.*

Under the committee bill, States would have the option to provide Medicaid coverage for community care for functionally disabled elderly individuals. This service, like other Medicaid benefits, would have to be offered on a statewide basis. Community care services could only be offered to individuals 65 and over who, on the basis of income and resources, are eligible for Medicaid and who, after a comprehensive functional assessment, are determined to be functionally disabled. Community care services would have to be provided in accordance with an individual community care plan established and periodically revised by a qualified community care case manager.

Federal Medicaid matching funds would be available for this benefit on the later of July 1, 1990, or 30 days after the issuance of interim regulations by the Secretary setting for minimum requirements for providers of community care and residential settings in which such care is delivered.

(b) *Community Care for Functionally Disabled Elderly Individuals.*

(1) *Community Care Defined.* Community care would include one or more of the following services: (1) homemaker/home health aide services; (2) chore services; (3) personal care services; (4) nursing care services provided by, or under the supervision of, a registered nurse; (5) respite care; (6) training for family members in managing the individual; (7) adult day health services; and (8) other home and community-based services (other than room and board) as the Secretary may approve. In the case of an individual with chronic mental illness, community care could, at State option, include day treatment or other partial hospitalization, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility). The bill does not require that the States electing this option offer "core" services; States covering community care may choose to cover any one or more of the services described above.

Under the committee bill, nursing care services, if offered under the community care benefit, would not include continuous nursing care services provided on a round-the-clock, 24-hour per day, 7 day-per-week basis; for individuals in need of nursing care of this intensity, the appropriate Medicaid benefit would be nursing facility care). Homemaker/home health aide services, chore services, personal care services, and nursing care services would, if covered, have to be provided in a place of residence used as the individual's home. Federal Medicaid matching funds would not be available for the costs of room and board.

(2) *Functionally Disabled Elderly Individual Defined.* Under the committee bill, to be eligible for this community care benefit, an individual would have to be (1) 65 years of age or older, (2) eligible for Medicaid in the community due to low income and resources (i.e., receiving Supplemental Security Income (SSI) or "spending down" to qualify as "medically needy"), and (3) determined to be "functionally disabled."

The bill would not alter current Medicaid rules for determining income or resource eligibility in the community, with two exceptions. First, States that were providing home and community-based services to the elderly under a 1915(c) waiver at the time they elect to offer optional community care services under the committee bill would be able to continue coverage of these individuals under the optional community care benefit, even if the incomes or resources of these individuals are greater than permitted under the State's community eligibility standards. The committee bill would not require States to discontinue their 1915(c) waivers. However, because under current law these waivers allow States to apply less restrictive eligibility criteria used for institutionalized individuals, many 1915(c) waiver beneficiaries, while functionally disabled, would not qualify for the community care benefit with its more restrictive community eligibility criteria. The committee bill would make these waiver beneficiaries eligible for the community care benefit.

However, a State would not be allowed to apply the less restrictive 1915(c) waiver eligibility criteria to functionally disabled elderly individuals who were not participating in the waiver at the time of its termination.

Second, States offering coverage to the "medically needy" would be allowed to use a 6-month projected income period in determining both initial eligibility and the amount of an eligible individual's income to be applied to the cost of care (this would parallel current law with respect to post-eligibility treatment of income for institutionalized individuals, 42 C.F.R. 435.725(f)(1)).

Since January, 1980, the State of Texas has provided personal care services to aged and disabled individuals under a waiver granted by the Secretary under section 1115 of the Social Security Act. This waiver authority was first extended by section 9523(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272), and again by section 411(k)(9) of the Medicare Catastrophic Coverage Act, Public Law 100–360, until January 1, 1990. Currently, 4900 aged and disabled individuals are receiving personal care services in the community under this waiver authority. These individuals meet the community (SSI) resource standard of $2,000, but have incomes between the community income standard (currently $368 per month) and the institutional income standard (currently $715 per month). To enable Texas to continue to divert functionally disabled individuals from nursing home placement, the committee bill would give Texas the option, upon expiration of its 1115 waiver, to extend personal care services (or any other community care service) to aged or disabled individuals who meet the waiver's test of functional disability and who meet the State's higher institutional income standard. Federal Medicaid matching funds would be available for State expenditures for this population on a permanent basis. The personal care services (and any other community care services) which the State elects to offer under its Medicaid program would be subject to the same minimum requirements set forth in the committee bill as those community care services offered by other States.

(3) *Determinations of Functional Disability.* As defined in the committee bill, an individual would be "functionally disabled" if the individual (1) due solely to physical impairment or due solely to mental illness, is unable to perform without substantial assistance from another individual at least two (or, at the option of the State, three or four of the following activities of daily living ("ADL's"): bathing, dressing, toileting, transferring, and eating; or (2) has a primary or secondary diagnosis of Alzheimer's disease.

Thus, under this definition, in order for an individual to be determined to be "functionally disabled", he or she, because of physical impairment, would have to be unable to perform, without substantial assistance from another individual, at least two of the ADL's specified in the bill; or he or she, because of mental illness, would have to be unable to perform, without substantial assistance from another individual, at least two of these ADL's; or he or she would have to have a primary or secondary diagnosis of Alzheimer's disease. An individual who, because of a combination of physical impairment and mental illness, is unable to perform, without substantial assistance from another individual, at least two of the

specified ADL's, is not "functionally disabled" for the purposes of the committee bill. In this context, "mental illness" is defined in the committee bill to mean a primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition).

The committee notes that, under this definition, elderly individuals who would be "functionally disabled" due solely to mental illness are treated in precisely the same manner as those who would be "functionally disabled" due solely to physical impairment. In the view of the National Mental Health Association and 10 other national organizations (including the American Psychiatric Association, the American Psychological Association, the Mental Health Law Project, and the National Association of State Mental Health Program Directors), this approach will "be . . . extremely beneficial to persons with mental illnesses". According to these groups, "[i]t will help relieve the pressure on the States to provide community services to individuals discharged or diverted from nursing facilities as a result of the pre-admission or resident assessments required under OBRA nursing home reform. The home and community services which can be covered under the new option . . . will also be beneficial to many other elderly persons with mental or physical impairments who are at risk of institutionalization" (June 28, 1989, letter to Members of the Subcommittee on Health and the Environment).

The committee notes further that the use of "activities of daily living" (as well as the actual ADL's specified in the bill) as a measurement for determining functional disability is consistent with the generally accepted views of long-term care experts that ADL's are the most appropriate, most well-developed method for assessing an individual's functional impairments or limitations. Indeed, the committee understands that processes, procedures, and instruments for determining ADL limitations have been in use for a number of years and that many States are already performing ADL assessments. Therefore, in the view of the committee, neither the States nor the Secretary (who would have the responsibility for designating one or more functional assessment instruments to be used by the States for making eligibility determinations), should have difficulty in implementing this part of the bill's eligibility requirements.

(4) *Assessments of Functional Disability.* Under the committee bill, an individual's "functional disability" would be determined on the basis of a comprehensive functional assessment conducted by an interdisciplinary team designated by the State. The assessment would be (1) used to evaluate an individual's ability to perform the 5 ADL's specified in the bill (bathing, dressing, toileting, transferring and eating), (2) based on a uniform minimum data set specified by the Secretary, and (3) conducted using a instrument specified by the State and approved by the Secretary. Any individual who is 65 years of age or older and who is eligible for Medicaid on the basis of income and resources would be able to request such an assessment (or have a such a request made on his or her behalf). Neither States nor any interdisciplinary teams designated by the States to conduct these functional assessments would be allowed to charge a fee for these assessments.

With respect to the assessment instrument itself, the committee bill would require the Secretary, by July 1, 1990, to (1) specify a minimum data set of core elements and common definitions to be used in conducting functional assessments, as well as guidelines for the use of the data set; and (2) identify one or more functional assessment instruments for use by a State in conducting comprehensive functional assessments. To expedite the development of the data set and the assessment instruments, the committee bill would waive the applicability of the Paperwork Reduction Act and Executive Order 12291 requirements under which the Office of Management and Budget is authorized to review agency reporting forms and information requests. States would have the option of using one of the instruments identified by the Secretary, or of using their own instruments, if those are approved by the Secretary as consistent with the minimum data set of core elements, common definitions, and utilization guidelines.

The committee intends that the comprehensive functional assessment instrument or instruments developed by the Secretary have the following characteristics. First, when used by a trained observer, the instruments should evaluate the ability of the individual to perform, without substantial assistance, each of the 5 ADL's specified in the bill. At the same time, the instruments must be able to distinguish ADL limitations due solely to physical impairment or due solely to mental illness. Second, when used by another trained observer on the same individual at the same time, the result of the assessment should be substantially the same as that obtained by the first observer. Finally, although the descriptive portions of the instrument should be designed to be helpful to a qualified community care case manager in planning individual community care plans (ICCP's), they should not allow for either a diagnostic characterization of the individual's functional status. In the committee's view, such an approach would result in opinions or conclusions about the individual's diagnosis, prognosis, or treatment that may not reflect the individual's current functional status and is, therefore, inappropriate.

With respect to the actual assessments, States would be required to designate interdisciplinary teams to conduct comprehensive functional assessment. Under the committee bill, States would be allowed to delegate this responsibility to other public or nonprofit private organizations under contract, but only if such organizations have no direct or indirect ownership or control interest in, or affiliation or relationship with, an entity that provides either community care or nursing facility services. States or their subcontractors would be specifically prohibited from charging any fees for an assessment. Their costs for conducting assessments would, however, be eligible for Federal Medicaid matching payments at the regular 50 percent administrative rate.

In conducting each assessment, an interdisciplinary team would be required to (1) identify the individual's functional disabilities (based on the 5 ADL's specified in the committee bill) and need for community care (based on social, cognitive, and other relevant factors, i.e., whether the individual is living alone or with others); and (2) determine, on the basis of the assessment, whether the individual is "functionally disabled." The results of these assessments

would be used in establishing, reviewing, and revising ICCP's for those individuals determined to be eligible for community care.

Under the committee bill, each functionally disabled elderly individual who receives community care would be required to have his or her comprehensive functional assessment reviewed and revised at least once every 12 months. In addition, each elderly individual who is determined not to be functionally disabled (and, therefore, ineligible for services) would be entitled to appeal any adverse decision relating to such a determination. States electing to provide Medicaid coverage for community care for functionally disabled elderly individuals would be required to establish a process by which such an appeal could be made.

(5) *Individual Community Care Plan (ICCP).* Once an individual is determined to be functionally disabled and eligible for community care, the committee bill would require that a written plan of care—an individual community care plan (ICCP)—be developed and periodically reviewed and revised by a qualified community care case manager. The ICCP would have to be based upon the individual's most recent comprehensive functional assessment and a face-to-face visit with the individual in his or her residence. The purpose of this visit requirement is to assure that the case manager is familiar with the current living arrangements of the individual and the implication of those arrangements for the ability to provide quality community care services to the individual. Functionally disabled individuals who disagree with the ICCP that is developed for him or her would have the right to appeal that determination under an appeal process which States would be required to establish.

The ICCP would specify the community care to be provided to each functionally disabled elderly individual. Although the ICCP could specify services that the State has not elected to cover under its Medicaid program, the individual would be entitled to have payment made only for community care that is within the amount, duration, and scope specified under the State's Medicaid program. For example, an ICCP may call for the provision of respite care. However, if the State Medicaid program covers only homemaker, chore, and personal care services, the individual is not entitled to Medicaid payment for respite care services.

Under the committee bill, the ICCP would have to reflect the individual's needs and preferences, consistent with the amount, scope, and duration limitations on community care services under the State's Medicaid program. The committee bill would not give the individual final authority with respect to the content of the ICCP; that must remain with the case manager, who would be accountable for the adequacy of the plan. However, it is the intent of the committee that the ICCP's be developed by the case manager with maximum input from, and involvement of, the beneficiary, so that the plans accurately reflect each beneficiary's unique needs and preferences, and so that each beneficiary understands his or her rights and responsibilities under the ICCP.

In this connection, the committee bill would require that each ICCP, to the extent feasible, allow for and promote the direction and oversight of community care by the beneficiary. In the view of the committee, one element essential to assuring quality in commu-

nity care services is the ability of beneficiaries to negotiate agreements with providers that will maximize each beneficiary's functioning, self-determination, and physical security, while recognizing any limitations on the capacities of providers or coverage under the State Medicaid program. Thus, the committee bill would entitle functionally disabled individuals to choose the providers from whom they will receive community care services.

While the State could designate an individual's case manager, neither the State nor the case manager would have the authority to limit beneficiary freedom of choice among qualified providers. A beneficiary would have the right to select any provider of community care, whether an agency or an individual, that meets the bill's requirements for participation. The committee bill makes clear that the State would not be authorized to permit payment for community care to be made through a qualified community care case manager; the State would have to pay the provider directly so that the case manager could not exert indirect control over the beneficiary's choice of provider. The intent of the committee is to assure that individuals receiving community care services have the ability to select and, to the extent feasible, direct their providers. The committee anticipates that beneficiaries would monitor the care they are receiving under their ICCP's and, in cases where the beneficiary believes the provider is not meeting its responsibilities, to resolve the matter directly with the provider, seek assistance from the case manager, or find another provider.

The ICCP would be limited in scope. Under the committee bill, case managers through the ICCP's could not direct the provision of Medicaid services other than community care, such as personal care services, rehabilitative services, or nursing facility services. Similarly, the committee bill would not authorize the case manager or the ICCP to exercise any control over the delivery of any home health or other long-term care services covered under Medicare or paid for by the individual from his or her own funds.

Under the committee bill, ICCP's would have to be established, reviewed, and revised by qualified community care case managers meeting the following criteria. First, a qualified case manager must be a public or private nonprofit organization. Private nonprofit organizations may be qualified as a community care case manager, however, only if they have no direct or indirect ownership or control interest in, or affiliation or relationship with, an entity that provides either community care or nursing facility services. Second, a qualified case manager must have experience in establishing, reviewing, and revising comprehensive functional assessments and in providing case management services to the elderly. The committee intends that such experience involve the development of assessments and the provision of case management services for individuals in need of the type of community care services specified in the bill. Third, a qualified case manager must have procedures for assuring the quality of services it provides and must meet quality standards established by the Secretary, including standards designed to assure that case managers are competent and that beneficiaries are protected against financial exploitation by case managers.

In addition to developing and revising the actual content of ICCP's, qualified case managers would be responsible for (1) assuring that community care services covered under the State Medicaid plan and specified in an ICCP are actually being provided; and (2) visiting each individual receiving such services in his or her residence at least once every 90 days. These requirements are designed to assure both program accountability and quality of care. Thus, the committee intends that case managers determine that all the covered community care services specified in an ICCP are actually delivered at the time and date so designated and make inquiries about the quality of the services provided. Moreover, the committee intends that case managers actually meet with the individual to whom community care services is being provided to make assessments about the individual's health status and continued need for community care services (whether or not specified in the individual's ICCP). The committee further expects case managers to monitor for any signs of abuse, neglect, financial exploitation, inappropriate involuntary restraint, or substandard quality of services by a community care provider or in a community care setting in which community care are delivered.

(c) *Ceiling on Payment Amounts and Maintenance of Effort.* To remain within the constraints established by the fiscal year 1990 Budget Resolution, the committee bill contains two provisions that would limit Federal Medicaid payments to States electing to offer community care to the functionally disabled elderly. The first is an aggregate ceiling on Federal Medicaid payments linked to payments for skilled nursing facilities (SNF's) under Medicare. The second is a requirement that States electing this option maintain their current fiscal effort in providing community care services to the frail elderly. The committee intends to monitor the implementation of these provisions to ascertain whether adjustments are needed.

(1) *Ceiling on Payment Amounts.* Under the committee bill, Federal Medicaid matching payments to a State for community care provided in any calendar quarter could not exceed 30 percent of the product of the following: (1) the average number of individuals receiving community care in the quarter, (2) the average per diem rate of payment for Medicare SNF services in that State for the quarter, and (3) the number of days in a quarter. Thus, in a State in which Medicare pays SNF's at an average rate of $80 per day, the maximum Federal Medicaid matching payments a State could receive for providing community care to an average of 1,000 functionally disabled elderly individuals in a quarter would be $2.16 million (0.30 $\times$ 1,000 beneficiaries $\times$ $80 $\times$ 90 days). This aggregate payment ceiling would apply regardless of the State's Medicaid matching rate.

(2) *Maintenance of Effort.* Under the committee bill, if a State wishes to offer Medicaid coverage for community care to functionally disabled elderly individuals, it must report to the Secretary, in a format developed or approved by the Secretary, the amount of non-Federal funds obligated by the State (and its localities) for the provision of community care to functionally disabled elderly individuals in Federal fiscal year 1989. State (and local) expenditures

for home and community-based services under a section 1915(c) waiver would not be subject to this reporting requirement.

The committee bill would require the Secretary, in determining the amount of Federal Medicaid matching funds to be paid to a State for community care, to reduce the total amount expended by a State (and its localities) for such services by the amount of expenditures reported by the State (for itself and its localities) for fiscal year 1989. The purpose of this requirement is to prevent States from using the option established by the committee bill to replace State (or local) dollars now being spent on community care for this population with Federal Medicaid dollars.

The committee stresses that a State which does not choose to offer the community care benefit is not required to file such a report. A State is not required to file a report at the close of fiscal year 1989 in order to retain its option to cover these services. For example, if a State does not opt to offer the community care benefit until fiscal year 1992, it would not have to file its report regarding expenditures for fiscal year 1989 until the beginning of the quarter in which the benefit is first offered.

The committee also notes that the only State and local expenditures subject to reporting are expenditures for community care as defined in the bill to functionally disabled elderly individuals as defined in the bill. Spending under a 1915(c) waiver would not have to be reported. Spending for community care for elderly individuals who are not functionally disabled as defined in the bill would not have to be reported. Spending for services that are not community care as defined in the bill, even if provided to functionally disabled elderly individuals, would not have to be reported.

The following example illustrates how the committee bill would prevent refinancing of current State or local expenditures. Assume that a State (and its localities) spent $500 million on community care for functionally disabled elderly individuals in fiscal year 1989 and that the State elects to offer the community care benefit in fiscal year 1991. In determining the amount of Federal Medicaid matching funds available to the State in connection with its fiscal year 1991 expenditures, the Secretary would first deduct $500 million from the total amount which the State reports it (and its localities) spent for community care for this population in fiscal year 1991 (excluding spending under a 1915(c) waiver). The Secretary would then apply the State's Medicaid matching rate to any excess. Thus, if the State (and its localities) spent a total of $510 million in fiscal year 1991, and the State's matching rate was 50 percent, the State would receive $5 million in Federal Medicaid matching funds. (This $5 million would also be subject to the ceiling on payment amounts established by the bill).

(d) *Minimum Requirements for Community Care.* As noted above, the committee views quality of care as a major concern in the provision of community care services to the functionally disabled elderly. Many of these services are delivered to the elderly in their own homes or in the homes of their families with whom they live, often making it difficult to monitor the quality of care that is provided. In many instances, they are also delivered in residential settings, such as board and care facilities, which are not required to meet any Federal quality standards and, indeed, are not even re-

quired to be licensed in a number of States. Charges of substandard care, neglect, abuse, and misappropriation of funds are neither uncommon nor, in many cases, unfounded.

In order to help assure that functionally disabled elderly individuals receive—and that Federal Medicaid dollars pay for—only quality community care services, the committee bill would mandate the Secretary to establish quality care requirements for both community care and "community care settings" (settings in which community care services are provided). Interim requirements would have to be published by July 1, 1990; final requirements, October 1, 1991. The Secretary would be prohibited from delegating this responsibility to the States. States would, however, be permitted to establish more stringent standards with respect to quality requirements applicable to community care providers or to "community care settings."

(1) *Minimum Requirements for Community Care Providers.* The committee bill would require the Secretary to establish Federal minimum quality requirements which would include (1) minimum competency qualifications for personnel providing community care; (2) guidelines for minimum compensation to assure the availability of competent personnel and to reduce the rate of turnover among such personnel; and (3) a specification of patients' rights (including the rights to free choice regarding services and treatment; to freedom from restraint; to privacy; to confidentiality of records; and to voice grievances). In addition, community care services would have to be provided in compliance with requirements developed by the Secretary designed to assure, through methods other than reliance on State licensure, that functionally disabled elderly receiving community care services are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of services by unqualified personnel.

Since many of the community care services provided for under the committee bill are often delivered by individuals who are not licensed health professionals, the committee intends that the Secretary establish Federal personnel competency qualifications that will ensure that such individuals are competent to provide whatever community care services they are expected to provide. For example, a home health aide who is, as part of his or her duties, required to help move an individual out of bed and into the bathroom, should be competent at this task before he or she is allowed to provide this type of care. Similarly, an aide who is required to bathe an individual as part of his or her duties should be competent to perform this task before being permitted to provide this service to the functionally disabled elderly. For services such as these, the committee expects the Secretary to set standards by which an individual's competency can be established and determined.

Because the individuals who provide community care services are usually less skilled in training, they are, in general, paid at only the minimum wage level. In addition, they are often required to perform work that is less attractive than other job opportunities for the same pay. As a result, current personnel are difficult retain and new workers are difficult to recruit. The committee is in-

formed that turnover rates are high and, as a result, there is little continuity of care.

In the committee's view, the most appropriate way to address this problem is for the Secretary to establish guidelines regarding minimum compensation for individuals who provide community care. The committee intends that such guidelines take into account the nature of the services to be provided (vis-a-vis other less skilled employment opportunities) as well as the level of functional disability of the individuals who are eligible to receive community care services. In addition, the committee intends that such guidelines consider the growing need for this type of caregiver and the importance of continuity in the provision of services.

In addition to these minimum quality requirements, community care services would have to be provided in accordance with the requirements established by the Secretary designed to assure—through methods other than State licensure—that functionally disabled elderly individuals are protected against abuse, neglect, financial exploitation, inappropriate involuntary restraint, and the provision of health care services by individuals who are not competent. The need to go beyond compliance with State licensure requirements is documented in the GAO's recent study on board and care facilities, *Board and Care: Insufficient Assurances That Residents' Needs Are Identified and Met,* in which investigators cite example after example of residents being abused and neglected, and receiving inadequate care in *licensed* facilities. In the committee's view, additional measures—such as competency evaluation requirements—must be taken by the Secretary to assure that functionally disabled elderly individuals are not subjected to these practices.

(2) *Minimum Requirements for "Community Care Settings".* Under the committee bill, "community care settings" would be defined as settings, in which community care is provided, that are either non-residential (e.g., facilities in which adult day health services are delivered) or residential (e.g., foster homes, board and care facilities, and other group living arrangements) in which more than two unrelated adults reside. (Nursing facilities would not be considered "community care settings" since the Medicaid statute already contains requirements for participation applicable to them.) "Community care settings" could not have, as persons with an ownership or control interest, any individuals who have operated facilities that have been found repeatedly to be substandard. Residential settings in which community care services are not provided to Medicaid-eligible residents would not be subject to these minimum requirements.

Since 1976, when Congress enacted the so-called "Keys Amendment" to the Social Security Act (which permitted Supplemental Security Income (SSI) payments to be made to individuals in small publicly-supported community residences), the number of elderly living in "community care settings" such as board and care homes, has grown considerably. Although the actual figure cannot be determined (because of the substantial number of unlicensed facilities), the recent GAO report, *Board and Care: Insufficient Assurances That Residents' Needs Are Identified and Met,* cites a estimate of over 260,000 board and care beds in approximately 10,000 facilities designated for serving the elderly. Many of the elderly

living in these facilities would undoubtedly qualify for community care under the committee's bill.

As discussed above, the need for minimum requirements for community care settings such as board and care homes is well-documented in this GAO study. In one State visited, for example, GAO investigators noted that during one 3-month period in 1987, 357 cases of abuse were reported, of which 180 were confirmed by State officials. In 73 percent of the confirmed cases, the abusers were employees of the board and care facilities. In another State, officials found that residents were forced to work in one board and care facility on a farm, and were subjected to physical abuse by the operators. And in still other States, inspectors found continuous violations regarding trash, improperly dispensed medications, lack of heat, absence of pest control, and insufficient food.

Similar conditions were also cited in a March 1989 report, *Board and Care Homes in America; A National Tragedy,* prepared by the House Select Committee on Aging's Subcommittee on Health and Long-Term Care (Comm. Rept. 101–711). That study reviewed the quality of care in board and care facilities over the last 10 years. Although GAO investigators were unable to obtain a great deal of information about *unlicensed* facilities, given the conditions described in the GAO and the Health and Long-Term Care subcommittee's reports, the committee agrees with the GAO conclusion that "undoubtedly, serious problems also exist in unlicensed homes".

The committee bill would not establish a program for directly regulating board and care facilities or similar residential settings. However, the committee insists that Federal Medicaid funds not be spent for services provided in settings that do not assure that residents are not subject to neglect, abuse, financial exploitation, or other harm. Otherwise, the Medicaid program would, in effect, be indirectly subsidizing substandard living arrangements. This the committee refuses to do.

Accordingly, the committee bill would establish a number of minimum requirements for community care settings in which community care is provided. Such requirements would include (1) specified residents' rights, including rights of incompetent residents, access and visitation rights, protection of resident funds, and restrictions on the use of physical or chemical restraints or psychopharmacologic drugs; (2) applicable licensing and life safety code standards; and (3) applicable sanitary and infection control standards. In addition to these requirements, these settings would have to meet requirements developed by the Secretary designed to assure, through methods other than reliance on State licensure, that the functionally disabled elderly receiving community care services are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of services by unqualified personnel.

The committee stresses that, in establishing minimum "requirements" for providers and for community care settings, the bill would not use the regulatory framework of "conditions" and "standards" that currently applies to SNF and ICF services. (The nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987, Public Law 100–203, established "requirements"

for participation by nursing facilities in Medicaid, effective October 1, 1990). It is the specific intent of the committee that, with respect to the provision of community care or the settings in which such care is provided, the Secretary assure compliance with each element of each minimum "requirement." The Secretary has no authority to redefine these "requirements" as "conditions" or "standards," or as "level A" and "level B" requirements.

(e) *Survey and Certification Process.* In order to assure compliance by providers and settings with the Federal minimum requirements regarding the health, safety, welfare, and individual rights of functionally disabled elderly individuals receiving community care services, the committee bill would require States to establish and implement a survey and certification process. Under this process, the State would be responsible for certifying, at least annually, the compliance of providers of community care services, and of "community care settings" in which such services are delivered, with the minimum requirements. In the case of providers and "community care settings" operated by the State, the Secretary would have this certification responsibility.

The committee bill would provide for two certification methods. With respect to community care providers (other than "community care settings" that are providers), certification would be based upon on a periodic performance reviews, rather than on-site surveys. With respect to "community care settings" (whether they are providers or settings in which community care is provided), certification would be based upon an unannounced, on-site survey using a protocol developed by the Secretary. To assure the adequacy of State surveys, the Secretary would be required to conduct "look behind" surveys in a sample of settings in each State using the same protocols. Results of all provider reviews and "community care setting" surveys would be available to the public and to State Medicaid Fraud Control Units.

In addition to their provider review and "community care setting" survey responsibilities, States would be required, through their survey agencies, to investigate allegations of individual neglect and abuse and misappropriation of personal property by personnel providing community care services, and allegations of individual neglect and abuse in "community care settings". If a State finds that a provider has delivered community care of substandard quality, or that a "community care setting" is substandard, the State would have to make a reasonable effort to notify family members and other individuals receiving community care services by that provider or in that setting. Both the States and the Secretary would be required to maintain adequate staff to investigate complaints of violations of requirements by providers or by "community care settings". Where the Secretary has reason to question the compliance of a provider or a "community care setting" with these requirements, the committee bill would authorize the Secretary to make an independent review or survey.

The committee notes that these survey and certification requirements would not apply to any State that does not elect to offer Medicaid coverage for community care services for functionally disabled elderly individuals. In addition, they would not apply with respect to services provided under a section 1915(c) waiver.

The Secretary would be required to develop protocols and methods for use by State surveyors in evaluating and assuring the quality of "community care settings." Survey protocols and methods relating to the interim requirements would have to be issued by July 1, 1990. Survey protocols and methods relating to the final requirements would have to be published by October 1, 1991. Effective January 1, 1992, no Federal Medicaid matching funds would be available to pay for community care provided to beneficiaries residing in "community care settings" that have not been subject to a State survey using the final version of the protocols and methods.

(f) *Enforcement.* With respect to providers of community care, the committee bill would provide for the use of two remedies by both the States and the Secretary to enforce the requirements of the bill: (1) termination of participation in the program, and (2) civil money penalties. States would be required to establish, by statute or regulation, a civil money penalty assessed and collected, with interest, for each day in which the provider is or was out of compliance with a requirement. The States would be responsible for enforcement in the case of providers other than those which they operate; the Secretary would be responsible for enforcement with respect to State providers. The Secretary would be given independent authority to impose civil money penalties of up to $10,000 for each day of noncompliance by either a State or private provider. The committee expects that, as under current law, the Secretary's civil money penalty authority under this bill will be exercised by the Inspector General.

Where noncompliance by a provider immediately jeopardizes the health or safety of beneficiaries, the committee bill would require both the State and the Secretary to either (1) take immediate action to remove the jeopardy and to correct deficiencies through the appointment of temporary management or (2) terminate Medicaid participation by the provider. The same requirement would apply with respect to "community care settings."

Where noncompliance by a provider does not immediately jeopardize beneficiary health or safety, the committee bill would authorize the State and the Secretary to apply any of the remedies available to them under State or Federal law, including civil money penalties. Both the State and the Secretary would have to develop criteria under which the penalties would become incrementally more severe for repeated or uncorrected deficiencies. Civil money penalties would not be applicable to "community care settings" that are not providers, since these settings do not directly receive Medicaid reimbursements. Instead, as described in section (g), the committee bill would simply deny Federal Medicaid matching funds for community care delivered to individuals residing in substandard or noncomplying "community care settings" (subject to a one-time 3-month grace period).

(g) *Payment for Community Care.* The committee bill would require that States pay for the community care services they elect to offer at rates which are reasonable and adequate to meet the costs of providing care, efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards. The committee notes that the applicable laws include the guidelines which the Secretary is required to promulgate

regarding minimum compensation for community care providers. The committee stresses that payment rates must be adequate to assure that the individuals who are provide hands-on community care are competent to perform the tasks expected of them under the ICCP and are willing to deliver such services for a reasonable period of time before moving on to other employment.

Under the committee bill, Federal Medicaid matching funds would not be available for the costs of a civil money penalty imposed by the State or the Secretary for noncompliance with the requirements of this bill or Medicaid program integrity provisions. Federal Medicaid matching funds would also be denied for legal expenses incurred by a provider in defending an action for a civil money penalty or exclusion from the program if there is no reasonable legal ground for the provider's case. In the committee's view, Federal Medicaid funds should not be used to subsidize litigation which does not raise reasonable objections but is primarily designed to delay the imposition of remedies so that the provider can continue receiving Medicaid payments.

To ensure that Federal Medicaid matching funds do not pay for substandard quality care, the committee bill would prohibit Federal financial participation in the following circumstances. First, payment could not be made for community care that does not meet the minimum requirements developed by the Secretary, including protections from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and incompetent providers.

Second, payment could not be made for community care that is provided in community care settings that (1) are found by a survey to be substandard or (2) do not meet one or more of the minimum requirements developed by the Secretary. The residents of a community care setting found to be substandard or out of compliance with the minimum requirements would be allowed to continue receiving Medicaid coverage for community care for up to 3 months while the setting eliminates its deficiencies. This opportunity to correct would apply only once with respect to each setting. Thereafter, payments for community care would not be made on behalf of residents in these settings from the day the settings are found to be substandard or not to comply with the minimum requirements.

Under the committee bill, Federal Medicaid matching funds would not be available for community care provided to a functionally disabled elderly individual by a member of the individual's family. In the committee's view, it would great difficulty in monitoring and assuring the quality of services in circumstances where the community care provider is a relative of the beneficiary.

(h) *Effective Dates.* The community care option would be effective on the later of (1) July 1, 1990, or (2) 30 days after the publication of interim regulations by the Secretary setting forth minimum requirements for community care providers and community care settings. The Secretary would be required to issue final regulations implementing the requirements for providers and community care settings by October 1, 1991. To expedite the publication of these interim and final regulations, the committee bill would waive application of the Paperwork Reduction Act and Executive Order 12291. Effective upon their publication, the Secretary's interim and final

requirements would apply to community care provided to the elderly by Arizona and any other State operating under a waiver granted by the Secretary under section 1115 of the Social Security Act.

PART E—HOSPICE COVERAGE

Sec. 4261—Mandating Hospice Coverage

(a) *In General.* Under current law, States may, at their option, offer hospice care to terminally ill individuals who elect these services in lieu of hospital, nursing facility, or other services. Hospices provide palliative treatment (i.e., care intended to comfort, not cure) to terminally ill patients, generally in their own homes. Hospice services include physicians' services, nursing care, medical social services under the direction of a physician, home health aide and homemaker services, medical supplies, bereavement counseling, and short-term inpatient care for pain control and symptom management. Except in the case of patients with AIDS, payment for short-term inpatient services is subject to an aggregate limit. To participate, hospice programs must make services available on a 24-hour basis and meet other Medicare standards. According to the National Governors' Association, as of March, 1989, 20 States offered hospice coverage under their Medicaid programs: Arizona, California, Connecticut, Delaware, Florida, Hawaii, Idaho, Illinois, Kentucky, Massachusetts, Michigan, Minnesota, Nebraska, New York, North Carolina, North Dakota, Rhode Island, Texas, Vermont, Wisconsin.

The committee notes that hospice care is a benefit available to all terminally ill Medicare beneficiaries, regardless of the State in which they reside. In the view of the committee, the hospice care benefit should also be available to low-income, terminally ill individuals who are not elderly or disabled Medicare beneficiaries, regardless of the State in which they reside. The committee recognizes that hospice services may frequently be sought by low-income persons with AIDS, few of whom are eligible for Medicare. The committee bill would therefore require all States to offer hospice coverage under their Medicaid programs. The requirement would take effect July 1, 1990, without regard to whether final implementing regulations have been issued.

(b) *Payment.* Under current law, States that elect to offer coverage for hospice care must pay for such services in the same amounts, and with the same methodology, as used under Medicare Part A. In the case of a terminally ill Medicaid-eligible beneficiary whose home is a nursing facility or intermediate care facility for the mentally retarded, the State may pay a separate rate to the hospice program in order to take into account the room and board furnished by the facility. The Medicaid statute defines room and board for this purpose to include the performance of personal care services, such as assistance in activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies.

It is has come to the attention of the committee that the Medicare hospice care rates may not adequately reflect the costs of caring for some classes of terminally ill patients, such as AIDS pa-

tients. The committee bill would therefore allow States, at their option, to set their hospice payment rates in amounts higher than the Medicare rates. As under current law, States would not be allowed to set rates lower than the Medicare rates, and would be required to use the Medicare methodology in establishing rates.

The committee is also informed that a number of States pay hospices substantially less for room and board than they pay to nursing facilities in which the hospice patients live. Once a resident of a nursing facility has elected hospice care, the State may no longer pay the nursing facility. Instead, the State pays the hospice, and the hospice enters into a written agreement with the facility, under which the hospice takes responsibility for the professional management of the patient and the facility provides room and board. The facility receives payment for room and board from the hospice. If the amount paid by the State to the hospice for room and board is lower than the facility's room and board rates, the hospice must make up the difference. If the room and board payment to the hospice is 30 or 40 percent lower than the nursing facility rate, as has been reported to the committee, it is obviously very difficult for a hospice to accept a nursing facility resident as a patient. In order to eliminate any financial disincentive hospices might face to accept Medicaid patients living in nursing facilities, the committee bill would require that States, in these circumstances, pay the hospice an additional amount equal to at least 95 percent of the rate that would have been paid by the State to that facility for the Medicaid beneficiary.

(c) *Clarifying Effect of Hospice Election.* Under current law, terminally ill Medicaid beneficiaries who elect hospice care must waive payment for services, such as hospital and nursing facility services, that are defined by the Secretary under Medicare as related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made or that are duplicative of hospice care. Medicare, under its hospice benefit, does not cover many of the non-skilled services that States cover under Medicaid, including personal care services. This attendant care and other personal care is essential to enabling terminally ill Medicaid beneficiaries who have no family or friends to remain at home. The committee is concerned that, if the current statutory language is interpreted to require a beneficiary to waive payment for personal care services, the practical effect will be to deny them access to hospice benefits at home, since the hospice rate under Medicare does not include a component for the cost of personal care services. The committee bill would therefore clarify that, in electing hospice care, a Medicaid beneficiary waives payment for services determined by the Secretary for which payment may otherwise be made under Medicare. Thus, a beneficiary would not be required to waive payment for personal care services, attendant care, and other services covered under the State's Medicaid program but not under Medicare.

PART F—MISCELLANEOUS

Sec. 4271—Amendments Relating to Nursing Home Reform

(a) *Moratorium on Implementation of February 2, 1989 Regulation.* On February 2, 1989, HCFA issued final regulations with a comment period which specified new and revised requirements long-term facilities must meet in order to receive Federal funds for the services they provide to their residents (54 Fed. Reg. 5316). Such facilities include skilled nursing facilities (SNF's) under Medicare, and SNF's, and intermediate care facilities [ICF's] and effective October 1, 1990, nursing facilities under Medicaid. The February 2nd final regulations followed the publication of a notice for proposed rule making (NPRM) for conditions of participation for Medicare and Medicaid long-term care facilities on October 16, 1987 (52 Fed. Reg. 38582). That NPRM was released prior to the passage of the nursing home reform legislation authorized by this committee and included in the Omnibus Reconciliation Act of 1987 (OBRA '87) (Public Law 100–203).

Despite the intervening enactment of OBRA '87, HCFA has not published a new NPRM on participation requirements for Medicare and Medicaid long-term care facilities. It has chosen instead to issue the February 1989 final regulations. According to the agency, such regulations are designed to implement the provisions of the October 1987 NPRM as well as those sections of the OBRA '87 legislation that HCFA has determined to be "self-executing".

Among the OBRA '87 requirements that are addressed in the February 2nd regulations are those relating to residents' rights; admission, transfer, and discharge rights; resident behavior and facility practices; quality of life; resident assessments; services for residents; infection control; physical environment; and administration. Under OBRA '87, these requirements are to take affect on October 1, 1990. The February 1989 final regulations mandate, however, that many of these requirements become effective August 1, 1989, 16 months prior to the deadline set in OBRA '87. A HCFA rule published on July 14, 1989, delays the final regulations' effective date until January 1, 1990 (54 Fed. Reg. 29717). Nonetheless, as currently structured, the February 2nd final regulations will be put into place—with no opportunity for public comment or for agency adjustments—well before the law's October 1, 1990, effective date.

In the view of the committee, the implementation of these regulations is premature and should be postponed. Indeed, even HCFA acknowledges that a delay "would be beneficial to all affected parties" (54 Fed. Reg. 29718). Thus, the committee bill postpones until October 1, 1990, the implementation of HCFA's February 2, 1989 final regulations. During the interim period, the committee would encourage HCFA to review these regulations and, where appropriate, to revise and reissue them with an opportunity for public comment, in accordance with both OBRA '87 and with the comments that HCFA has already received since the regulations' publication last February.

With respect to the content of the February 2, 1989 final regulations, the committee takes issue with HCFA's claim in the preamble that "OBRA '87 was written with both the recommendations of

the IoM and *our [October 16, 1987] NPRM as a model"* (emphasis supplied). For the record, the committee wishes to inform the agency that the only blueprint for congressional action on nursing home reform legislation in 1987 was the congressionally mandated Institute of Medicine study, *Improving the Quality of Care in Nursing Homes.* (Note that legislation on Medicaid nursing home reform was first introduced on May 5, 1987 [H.R. 2270], some 5 months prior to the publication of the October 1987 NPRM. Similar legislation relating to Medicare nursing home reform was introduced on June 24, 1987 [H.R. 2770], 4 months ahead of the NPRM). Thus, the committee never intended—and does not intend now—that HCFA use its October 1987 NPRM as the basis for developing and implementing OBRA '87.

(b) *Nurse Aide Training.* Under current law, effective January 1, 1990, all nurse aides used by nursing facilities participating in Medicaid must (i) have completed, within 4 months, a training and competency evaluation program approved by the State; and (ii) be competent to provide nursing-related services.

OBRA '87 required the Secretary to establish requirements for State nurse aide training and competency evaluation programs and State nurse aide competency evaluation programs by September 1, 1988. Pending the publication of regulations establishing such requirements, HCFA has issued a guidance document, effective May 12, 1989 (HCFA Transmittal No. 62, Sections 2504–2512 (April 1989), which sets out approval criteria for the States. This delay has resulted, in some instances, in States postponing either the development of appropriate training and evaluation programs or the approval of qualified training and evaluation programs that are already in operation. It has resulted, too, in confusion among the States, nurse aides, and the nursing home industry.

In response to these concerns, the committee bill contains a number of provisions designed to clarify the structure and operation of the OBRA '87 nurse aide training and competency evaluation requirements.

(1) *Delay in Requirement.* In order to ensure that State nurse aide training and competency evaluation programs and State nurse aide competency evaluation programs are effectively qualified, approved, and put into place, the committee bill delays from January 1, 1990, until October 1, 1990, the date by which nurse aides must complete a competency evaluation program and be determined to be competent to provide nursing-related services.

The committee notes, however, that a number of States have already begun to implement the nurse aide training and competency evaluation provisions of OBRA '87 and would encourage such States to continue those activities. It would also encourage all other States to begin implementation of these requirements as soon as possible. The committee further notes that the enhanced Medicaid matching rate for nurse aide training and competency evaluation programs provided for under OBRA '87 continues through the third quarter of fiscal year 1990, or until July 1, 1990. The October 1, 1990 delay for which the committee bill provides does not change the conditions for, or the expiration date of, this enhanced matching rate.

(2) *No Compliance Actions Before Effective Date of Guidelines.* In light of the confusion that has resulted from HCFA's delay in publishing regulations relating to nurse aide training and competency evaluation programs and to nurse aide competency evaluation programs, the committee bill prohibits the Secretary from taking any compliance action against any State that has a made a good faith effort, prior to May 12, 1989 (the effective date of HCFA's interpretative guidelines), to comply with these OBRA '87 requirements. Such efforts would include a State's approval (prior to May 12, 1989) of a nurse aide training and competency evaluation program which the State had reasonably believed, at the time it made its certification, was in compliance with the OBRA '87 requirements. However, for periods occurring after May 12, 1989 and until HHS nurse aide training regulations are effective, the committee intends for States to meet fully, the requirements of the statute, as specified in HCFA's May 1989 guidance document (as periodically updated).

In providing for this good faith exception, the committee emphasizes that the Secretary's past failure to implement the OBRA '87 nurse aide training and competency evaluation provisions through regulation, while, regrettable, should not be construed to undermine the validity of the requirements specified in HCFA's May 12, 1989 interpretative guidelines. OBRA '87 did not mandate that the Secretary issue such regulations and explicitly did not predicate implementation of the nurse aide training and competency evaluation requirements upon the issue of final regulations.

(3) *Publication of Proposed Regulations.* The committee bill requires the Secretary to promulgate proposed regulations to implement OBRA 87's nurse aide training and competency evaluation requirements within 90 days of enactment of this Act. The committee intends for such proposed regulations to include among its requirements the items and issues discussed throughout section 4271(b).

Because nurse aides provide most of the "hands-on" care to nursing facility residents, the nurse aide training requirements were—and continue to be—one of the cornerstones of OBRA '87. Accordingly, HCFA's missed deadlines for taking interim steps towards full implementation of these requirements have become of particular concern to the committee as October 1, 1990 (the date on which the entire nursing home reform law becomes effective) quickly approaches. Effective as of that date, States will be able to waive the statute's minimum nurse staffing requirements (with respect to both registered nurses and licensed practical nurses) in all nursing facilities, and in turn, to leave residents under the exclusive care of nurse aides.

The committee stresses that, while it expects the Secretary to issue proposed regulations in a timely manner, the failure of the Secretary to issue proposed (or final) regulations, as required under the committee bill, does not, and is not to be construed to, delay the applicability of the statutory requirements relating to nurse aide training and competency evaluation. Under current law, these requirements are effective January 1, 1990 (and under section 4271(b)(1), above, October 1, 1990), without regard to whether final implementing regulations have been published. If such requirements were conditioned on the Secretary's taking specific actions,

the Secretary would have the ability to forestall—in violation of the intent of OBRA '87—the implementation of these critical protections against the provision of substandard care. The Secretary was not given this power in OBRA '87 and the committee declines to give it to him now.

(4) *Clarification of Grace Period for Nurse Aide Training of Individuals.* Under current law, effective January 1, 1990, a nursing facility participating in Medicaid may not use (on a full-time, temporary, per diem, or other basis) any individual as a nurse aide for more than a 4-month period unless the individual has completed an approved nurse aide training program and is determined to be competent to provide nursing related services.

As discussed in section 4271 (b)(1), above, under the committee bill, the January 1, 1990 effective date would be postponed until October 1, 1990.

This section of the bill simply clarifies what Congress had originally intended in enacting the OBRA '87 requirements relating to the use of nurse aides: no individual may work as a nurse aide for more than 90 days at any point in his or her career without having completed an approved nurse aide training and competency evaluation program and without having demonstrated competency to provide nursing and nursing-related services. This requirement applies whether such an individual is an employee of a nursing facility or is a per diem worker from an agency pool. For example, an individual may perform nurse aide work as an employee of nursing facility "A" for 70 days, then quit and obtain employment at nursing facility "B". Under the committee's bill, it is now clear that this individual could be used as a nurse aide at facility "B" (or any other nursing facility) for only 20 days without having completed an approved training and competency evaluation program and without having demonstrated competency to provide services. Similarly, if an individual is employed by an agency (or as an independent contractor) and works 15 days at nursing facility "A", 15 days at nursing facility "B", 15 days at nursing facility "C", and 45 days at nursing facility "D", such individual may not be used as a nurse aide by any other nursing facility until he or she has completed an approved training and competency evaluation program and has demonstrated competency.

The committee bill includes this clarification not only to explain its purpose in enacting the OBRA '87 requirements regarding the use of nurse aides, but also to stress its intent that the 90-day exemption from the training and competency evaluation requirements is only a grace period, not a "loophole" for circumventing the law.

(5) *Requirements for Training and Evaluation Programs.* Under current law, effective January 1, 1989, States are required to specify those approved nurse aide training and competency evaluation programs and, approved nurse aide competency evaluation programs, that meet the minimum requirements for those programs as set forth in OBRA '87. For nurse aide training and competency evaluation programs, these requirements relate to covered subject matter; the minimum number of training hours; training; instructor qualifications; and the procedures for determining competency. For nurse aide competency evaluation programs, these require-

ments relate to the covered subject matter and the procedures for determining competency.

It has come to the attention of the committee that several States have approved—or plan to approve—programs which include elements that OBRA '87 *never* intended to be a part of the training and evaluation process. In the committee's view, these elements act as obstacles both to the retention of currently employed nurse aides and to the recruitment of new candidates. Of particular concern are those programs which impose charges or fees for textbooks and other related course material, and those programs which require that the competency of nurse aides be determined solely on the basis of a written examination or which require nurse aides to travel unreasonable distances in order be evaluated. The committee bill includes a number of provisions designed to clarify the intent of OBRA '87 with regard to these practices.

With respect to charges for textbooks or related course material or for the competency evaluation itself, the committee bill requires that approved training and evaluation programs specifically prohibit the imposition of such charges on nurse aides. It is well known that nurse aides are among the nursing home industry's lowest paid workers, with wages at or near the minimum wage. In the committee's view, the imposition of any charges relating to training and competency evaluation on these employees would be a real hardship for them. This action would also discourage other individuals to seek work as a nurse aide. Such a result would be both contrary to the intent of Congress and to the best interests of nursing home residents who need nurse aide services.

With respect to competency determinations, the committee bill requires that approved training and competency evaluation programs provide for procedures which allow nurse aides, at their option, (i) to establish competency through procedures or methods other than the passing of a written examination; and (ii) to have the competency evaluation conducted at the nursing facility at which they are (or will be) employed (unless such facility is not in compliance with the OBRA '87 mandates).

In the committee's view, even well-trained, experienced nurse aides, by virtue of either their educational background or their usual nursing facility responsibilities, may be intimidated or threatened by the idea of being "tested" through the use of a written examination. Moreover, the committee believes that, considering the tasks that nurse aides generally perform, there are other, perhaps more appropriate and less formal ways of evaluating nurse aide competency. Indeed, the Conference Report that accompanied OBRA '87 (H. Rept. 100–495) noted that the word "testing" was struck from the agreement and replaced with the words "competency evaluation" in order "to emphasize that [training and competency evaluation] programs shall include manual and oral evaluation" (emphasis added) (p.678). The committee agrees and affirms the position taken in the OBRA '87 Conference Report (as quoted above). Thus, the committee stresses again, as it did in 1987, its intent that nurse aides be evaluated under methods or procedures that are the most comfortable, the most appropriate, and the most reasonable for them.

In response to these views, the committee believes HCFA should be take appropriate action (through its interpretive guidelines and forthcoming regulations) to ensure that both manual and oral methods of competency evaluation—at a minimum—are available to nurse aides. In the committee's view, too, States should not approve any training and competency evaluation program in which such methods are not offered. Under the committee's bill, it is clear they cannot do so. It is also clear that individual nurse aides—and not the State and not the nursing facilities—have the right to choose for themselves, within reason, the process or procedures by which they are to be evaluated. Thus, the committee does not intend that a request from a nurse aide working in Pennsylvania to have a competency evaluation performed in California, be granted. It does intend, however, that there be several methods of competency evaluation available to nurse aides and that each individual nurse aide be able to choose among them or any other reasonable competency evaluation procedures.

In requiring that approved programs permit nurse aides to have their competency evaluation conducted at the nursing facility at which they are or will be employed, the committee again believes that it is simply clarifying the intent of OBRA '87, that is, nurse aides should be evaluated for competency in a manner that is the most reasonable and least burdensome for the aides themselves. In the committee's view, this standard does not include training and competency evaluation program requirements which demand that nurse aides travel significant distances for their competency evaluation. Nor does it include any other program requirement, such as a travel mandate, that would involve relatively great expense (in relation to nurse aides' income) to nurse aides who wish to be evaluated.

The committee bill makes it clear, therefore, that individual nurse aides have the right to be evaluated in the nursing facility at which they are or will be employed. An aide is not entitled to exercise this right, however, if he or she is used or is to be used in a nursing facility that has been determined to be out of compliance with OBRA '87 requirements within the previous 2 years. In such instances, the committee intends that aides who express a preference, be evaluated at the most convenient, alternative location available.

This section of the committee bill also corrects an inconsistency in the minimum requirements for approved training and competency evaluation programs and approved competency evaluation programs with regard to the subject matters they are to cover. The committee bill simply clarifies that both such programs must include skills relating to the care of the cognitively impaired residents.

(6) *Delay and Transition in 75-hour Training Program Requirement.* Under current law, approved nurse aide training and competency evaluation programs must, among other requirements, provide for a minimum of 75 hours of initial training. As noted above, current law also provides that, effective January 1, 1990, all nurse aides used by nursing facilities participating in Medicaid must (i) have completed such an approved training and competency evaluation program within 4 months; and (ii) be competent to provide

nursing related services. The committee bill considers this requirement to be met with respect to nurse aides, who as of July 1, 1989, have completed a training and evaluation program of at least 60 hours and have received up to 15 hours of supervised practical training or regular in-service education.

(7) *Clarification of State Responsibility to Determine Competency.* Under OBRA '87, States are specifically required to make determinations about the competency of individual nurse aides to provide nursing related services. OBRA '87 also specifically prohibits States from delegating this responsibility to a nursing facility. It has come to the attention of the committee, however, that some States may be circumventing this prohibition by entering into subcontracts with nursing facilities (or entities related to nursing facilities) to carry out the States' responsibility to make nurse aide competency determinations. Under the committee bill, such subcontracts (or any other legal device designed to relieve a State directly or indirectly of its duty to conduct nurse aide competency evaluations), are specifically prohibited.

(8) *Clarification of Temporary Enhanced Federal Financial Participation for Nurse Aide Training By Nursing Facilities.* Under OBRA '87, Federal Medicaid matching funds are available for State expenditures with respect to nurse aide training and competency evaluation programs, and competency evaluation programs, regardless of whether the programs are conducted in or outside of nursing facilities, and regardless of the skill of the personnel involved in such programs. During the period July 1, 1988, to July 1, 1990, the matching rate on these expenditures is the lesser of (i) 90 percent or (ii) the State's regular matching rate plus 25 percentage points.

The committee bill clarifies that the expenditures subject to Federal matching at the enhanced matching rate during the July 1, 1988 to July 1, 1990 period include the costs for nurse aides to complete competency evaluation programs, regardless of whether the programs are conducted in or outside of nursing facilities. Effective July 1, 1990, expenditures attributable to nurse aide training and competency evaluation programs, and competency evaluation programs, are subject to a 50 percent matching rate.

Under current law, as a general rule, Medicaid funds are available only for expenditures attributable to Medicaid beneficiaries. One exception is the start-up expenditures for nurse aide training and competency evaluation. The committee bill clarifies that the Secretary may not take into account, or allocate amounts expended for nurse aide training and competency evaluation on the basis of the proportion of nursing facility residents entitled to Medicare or Medicaid. This prohibition applies with respect to expenditures for activities under nurse aide training and competency evaluation programs, and competency evaluation programs, prior to October 1, 1990. Thereafter, the committee expects that the costs of nurse aide training and competency evaluation, subject to Federal matching payments, will be allocated on the basis of the proportion of residents eligible for Medicare and Medicaid.

(9) *Effective Dates.* The committee bill provides that, except for those changes made under section 4271(b)(5) above, all of the amendments made with respect to the OBRA '87 nurse aide train-

ing and competency evaluation requirements are to take effect as if they were included in the enactment of OBRA '87. With respect to the amendments made under 4271(b)(5) (relating to requirements for training and evaluation programs), the bill provides that those modifications are to apply to nurse aide training and competency evaluation programs, and to nurse aide competency evaluation programs, offered on or after 90 days after the enactment of this Act.

(c) *Preadmission Screening and Annual Resident Review.* The preadmission screening and resident review (PASSAR) process established under OBRA '87 has two components: (1) preadmission screening; and (2) annual resident review. It is intended to prevent the inappropriate placement of individuals with mental illness or mental retardation in nursing facilities. It is also intended to ensure that Federal funds are not used to pay for inappropriate nursing facility care.

Under current law, prior to admission to a nursing facility, States are required to screen, all individuals (including those eligible for Medicare and those using private, personal funds or private long-term care insurance) with mental illness or mental retardation to determine whether they require the level of services provided by a nursing facility. Effective January 1, 1989, nursing facilities participating in Medicaid may not admit any individual with mental illness or mental retardation who has been determined by the State not to require such care.

Current law also requires States to review, on an annual basis, all residents (including those eligible for Medicare and those using private, personal funds or private long-term care insurance) with mental illness or mental retardation to determine whether nursing facility placement continues to be appropriate. The first round of these annual reviews must be completed by April 1, 1990. Individuals who have resided in nursing facilities for less than 30 months and who do not require nursing facility care must be discharged in an orderly manner. The Secretary has been authorized to approve, prior to April 1, 1989, State alternative disposition plans (ADP's) for the implementation of this requirement. It is the committee's understanding that HCFA has approved the ADP's of 47 States.

The law exempts individuals with a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) from both components of the PASSAR process.

OBRA '87 directed the Secretary to issue, by not later than October 1, 1988, minimum criteria for States to use in making PASSAR determinations. Pending final regulations, HCFA issued a series of draft guidelines, culminating in interim guidelines, effective May 26, 1989 (HCFA Transmittal No. 42, Sec. 4250–4253 (May 1989)) for States to use in implementing this requirement. In some instances, this delay has resulted in confusion and difficulty in implementing the PASSAR requirements.

In response to these concerns, the committee bill contains a number of provisions designed to clarify the structure and operation of the PASSAR requirements. The committee emphasizes, however, that while the bill makes some adjustments in the OBRA '87 requirements, it has not changed or in any way modified, its view on the need for these provisions. Indeed, the committee reaffirms its position that these requirements are fundamental for the

protection of individuals with mental illness or mental retardation against inappropriate institutionalization.

The committee notes further that, despite the delays in the Secretary's issuance of Federal criteria for State PASSAR determinations, the implementation of the OBRA '87 PASSAR requirements is already well underway in the States. The National Mental Health Association, on behalf of itself and seven other national organizations (including the National Association of State Mental Health Program Directors and the National Association of State Mental Retardation Program Directors) has informed the committee that many individuals have already been through the screening process, and that States are addressing the need for alternative community-based services for those found not to need nursing facility care. These organizations conclude that "the PASSAR process is vitally important for people with mental retardation and related conditions and with mental illness" (June 27, 1989 letter to Subcommittee Chairman Henry A. Waxman). The committee agrees and does not intend, through the provisions related to the OBRA '87 PASSAR requirements discussed below, to disrupt, delay, or interfere with this implementation process in any way.

(1) *No Compliance Actions Before Effective Date of Guidelines.* As noted above, OBRA '87 directed the Secretary to issue, by not later than October 1, 1988, minimum criteria for States to use in making PASSAR determinations. In light of the confusion that has resulted from HCFA's delay in publishing these criteria, the committee bill prohibits the Secretary from taking any compliance action against any State that has made a good faith effort, prior to May 26, 1989 (the effective date of HCFA's interpretative guidelines), to comply with these requirements of OBRA '87. However, for periods occurring after May 26, 1989 and until final PASSAR regulations are effective, the committee intends for States to meet fully, the requirements of the statute, as specified in HCFA's guidance document (as periodically updated).

In providing for this good faith exception, the committee emphasizes that the Secretary's past failure to implement the OBRA '87 PASSAR provisions through regulation, while, regrettable, should not be construed to undermine the validity of the requirements specified in HCFA's May 26, 1989 interpretative guidelines. OBRA '87 did not mandate that the Secretary issue regulations and explicitly did not predicate implementation of the PASSAR requirements upon the issuance of final regulations.

(2) *Publication of Proposed Regulations.* The committee bill requires the Secretary to promulgate proposed regulations to implement the OBRA '87 PASSAR requirements within 90 days of the enactment of this Act. The committee intends that such proposed regulations include among their requirements the items and issues discussed throughout section 4271(c).

The committee stresses that, while the committee expects the Secretary to issue proposed regulations in a timely manner, the failure of the Secretary to issue proposed (or final) PASSAR regulations, as required under the committee bill, does not, and is not to be construed to, delay the applicability of the statutory requirements relating to preadmission screening or annual resident review. As under current law, these requirements are effective Jan-

uary 1, 1989, without regard to whether final implementing regulations have been published. If such requirements were conditioned on the Secretary's taking specific actions, the Secretary would have the ability to forestall—in violation of the intent of OBRA '87—the implementation of these critical protections against the inappropriate institutionalization of individuals with mental illness or mental retardation. The Secretary was not given this power in OBRA '87 and the committee declines to give it to him now.

(3) *Clarification with Respect to Admissions and Readmission From a Hospital.* Under current law, all individuals with mental illness or mental retardation (with the exception of (i) those persons with a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) and (ii) those persons who have resided in a nursing facility for 30 months are longer) are subject to the PASSAR requirements. Since the preadmission screening requirements were put into place on January 1, 1989, however, the committee has learned that, in some instances, the screening process is being inappropriately applied. Thus, the committee bill clarifies two exceptions to the preadmission screening component of the PASSAR program. No changes are made, however to the annual resident review component.

The first exception clarifies that nursing facility residents (that is, those individuals who have already been admitted to a nursing facility) who are being readmitted to the nursing facility after a hospital stay are not subject to the preadmission screening requirements. Since these individuals have already been admitted to a nursing facility (and, in appropriate cases, have already met the applicable preadmission screening requirements), it was never intended for them to undergo a second screening upon their readmission to the nursing facility. The committee bill makes this explicit in the law.

The second exception applies to individuals who seek admission to a nursing facility directly from a hospital and who are expected to remain in the facility only briefly. Under this exemption, an individual (i) who is admitted to a nursing facility directly from a hospital after receiving acute inpatient care at the hospital; (ii) who requires nursing facility services for the condition for which he or she received care in the hospital; and (iii) whose attending physician has certified, before admission to the nursing facility, that he or she is likely to require less than 30 days of nursing facility services, is not subject to the preadmission screening requirements. Such an individual must meet all three of these conditions in order to be eligible for the exemption. Thus, for example, an individual who has been hospitalized with a stroke; who seeks admission, directly from the hospital, to a nursing facility for facility services required for treating the effects of the stroke; and who is certified by his or her physician to need no more than 30 days of facility care for such services, is not required to undergo preadmission screening under the committee's bill. However, should this individual have a mental illness or mental retardation and remain in the nursing facility beyond 30 days, he or she is still subject to PASSAR's annual resident review process.

(4) *Charges Applicable in Cases of Certain Medicaid-Eligible Individuals.* Under current law, providers participating in Medicaid, in-

cluding nursing facilities, must accept payment made by the State on behalf of eligible beneficiaries as payment in full. The only exception to this is that providers may collect nominal cost-sharing obligations which the State is allowed to impose on certain classes of beneficiaries; however, eligible residents in nursing facilities who are required to apply most of their income to the cost of care are not subject to cost-sharing. The purpose of this mandatory assignment requirement is to protect low-income individuals from excess provider charges.

There are circumstances in which, under current law, a State may not actually be making payments to a nursing home on behalf of a resident who is eligible for Medicaid. For example, a nursing home resident may be receiving Veterans' Administration aid and attendance payments. In a State which covers institutionalized individuals with incomes below 300 percent of the SSI benefits level, these payments are not taken into account in determining initial eligibility for Medicaid. However, these payments are considered in determining, post-eligibility, the amount of an individual's monthly income that is available to be applied to the cost of care.

Assume a State which sets its 300 percent eligibility threshold at $1,104 per month and which pays for nursing facility care at $1,165 per month (an ICF rate of $38.83 per day). If a resident has a monthly income of $1,250, of which $150 is Veterans' aid and attendance benefits, then the resident will be eligible for Medicaid ($1,100 is lower than the $1,104 income threshold), but the State will not actually make any payment ($1,250, less a $30 personal needs allowance, leaves $1,220, which exceeds the cost of care to the State of $1,165). It is the understanding of the committee that, in such circumstances, nursing facilities have charged these residents at "private pay" rates which are significantly higher than the Medicaid payment levels, even though these residents are Medicaid eligible.

The committee bill clarifies that, in such cases, nursing facilities may not charge more than the rate which the State has established under its Medicaid plan. The committee bill prohibits a nursing facility participating in Medicaid from imposing charges for Medicaid-eligible individuals for covered services that exceed the payment amounts established by the State for those services. This prohibition specifically applies in situations where the State is not making any payment to a nursing facility on behalf of a Medicaid-eligible resident because the individual's post-eligibility income exceeds the payment amounts established under the State's Medicaid plan.

(5) *Delay in Application to Private Pay Residents.* Under current law, both components of the PASSAR requirements—the preadmission screening and the annual resident review—apply to all individuals with mental illness or mental retardation who seek admission to a nursing facility, regardless of their source of payment for services. The committee bill delays the application of each of these requirements with regard to so-called "private pay" individuals (that is, those individuals who, at the time of their admission, are not entitled to Medicaid services) until they establish eligibility for Medicaid. If a "private pay" individual never qualifies for Medicaid, these requirements would not apply.

With respect to the application of the preadmission screening requirements, the committee bill postpones the timing of the screening for a "private pay" individual with mental illness or mental retardation from the point at which he or she seeks admission to a nursing facility until the point at which he or she establishes Medicaid eligibility for nursing facility services. At that juncture, as the committee bill provides, such individual must undergo, within a 24-hour period, a preadmission screening (just like any other non-"private pay" person would have to do in order to be admitted to a nursing facility). If as a result of the screening, it is determined that the individual does not require nursing facility services, the individual cannot remain in, or be admitted to, the facility.

With respect to the application of the annual resident review requirements, the committee bill also postpones the timing of the review for a "private pay" individual with mental illness or mental retardation until the point at which the individual establishes Medicaid eligibility for nursing facility services. Once the individual becomes Medicaid eligible, he or she is subject to a resident review at least once a year. Again, should it be determined on the basis of such review that the individual does not require nursing facility services, the current annual resident review requirements are to be applied and the individual must be discharged from the nursing facility (unless he or she has resided in the facility for 30 months or more).

The committee emphasizes that its bill delays the application of OBRA '87's PASSAR requirements to "private pay" residents until they become eligible for Medicaid. It does not, however, exempt them from these requirements altogether (unless they have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder). Thus, the committee reaffirms its conviction that individuals with mental illness or mental retardation who do not require nursing facility services should not reside in nursing facilities. This principle applies whether an individual is Medicaid eligible or not.

The purpose of the OBRA '87 PASSAR requirements is to assure that an independent determination is made of an individual's need for institutional placement. The committee bill simply postpones this determination until the point at which the individual becomes eligible for Medicaid. Thus, unless a State has its own preadmission screening and resident review requirements, individuals would be free to spend their own resources on nursing facility care. However, upon qualifying for Medicaid, an individual is subject to the program's interest in appropriate placement and appropriate expenditures of funds, and must, therefore, undergo the PASSAR process.

In light of these modifications to the PASSAR requirements, the committee does not believe it is appropriate to impose sanctions on those States which have failed, since January 1, 1989 (the date on which PASSAR's preadmission screening component went into effect), to screen "private pay" individuals for admission to a nursing facility participating in Medicaid. Accordingly, the committee bill prohibits the Secretary from taking such actions under these circumstances. The Secretary must, however, impose and continue to impose sanctions on those States which have failed to demon-

strate (to the satisfactory of the Secretary) that they have made a good faith effort to comply, between January 1 and May 26, 1989 (the date on which HCFA's PASSAR interpretative guidelines went into effect), with all other PASSAR requirements (see section 4271(c)(1), above).

The committee is aware that a number of States have developed their own preadmission screening programs that require a review of all persons who seek admission to a nursing facility participating in Medicaid—regardless of their source of payment. The committee, in including the provisions described above, has no intention of disrupting or interfering with the operation of such programs or of changing such programs' standards for admitting or retaining or making payment for, residents of nursing facilities participating in Medicaid. Thus, the committee bill expressly states that these changes to the PASSAR provisions of OBRA '87 are not to be construed as prohibiting States from developing and conducting preadmission screening programs which screen and periodically review all applicants and residents including those that are "private pay."

(6) *Denial of Payments for Certain Residents Not Requiring Nursing Facility Services.* Under current Medicaid law, no Federal matching payments may be made for covered services which are not medically necessary. Such services include those provided by a nursing facility.

One exception to this principle was established in OBRA '87. It provides that individuals with mental illness or mental retardation who have resided in a nursing facility for 30 months or more may elect to remain in such facility even though they do not require nursing facility services. Under these circumstances, a State cannot be denied Federal matching payments for reimbursement to nursing facilities for any services provided to these individuals.

The committee bill simply clarifies that (with the exception of those residents who meet the requirements of the 30-month rule described above), no Federal Medicaid matching funds are available for nursing facility care furnished to any individual who does not require the level of services provided by a nursing facility.

The committee recognizes that, under current law, some persons who are eligible for Medicaid are not subject to the OBRA '87 preadmission and annual resident review determinations which indicate whether individuals require the level of services provided by a nursing facility. The committee expects, however, that with respect to these individuals, States will use other utilization review methods designed to assure that Federal Medicaid matching funds are not paying for nursing facility services that are not required.

(7) *No Delegation of Authority to Conduct Screening and Reviews.* Under OBRA '87, State mental health and mental retardation authorities are required to conduct both components of the PASSAR process and to make independent determinations about the nursing facility requirements of individuals with mental illness or mental retardation. Although OBRA '87 did not specifically prohibit the States from delegating these responsibilities to nursing facilities themselves, it was never the law's intention to allow facilities to be able to conduct these activities. Since nursing facilities have a direct interest in the eligibility determinations that are to be made

for those individuals subject to the PASSAR requirements, there is a potential conflict of interest in permitting them to make these determinations. Thus, it was the committee's view in 1987—as it is today—to prohibit nursing facilities (or any of their related entities) to participate, in any way, in the PASSAR process.

It has come to the attention of the committee, however, that some State mental health and mental retardation agencies (or other appropriate State authorities) may be circumventing the intent of OBRA '87 that PASSAR determinations be made independent of a nursing facility by entering into subcontracts with nursing facilities (or related entities) to carry out the States' responsibility to conduct preadmission screenings and annual resident reviews, and to make determinations about individuals' nursing facility requirements based upon these screenings or reviews. Under the committee bill, such subcontracts (or any other legal device designed to relieve a State directly or indirectly of its duty to perform the PASSAR requirements), are specifically prohibited.

(8) *Annual Reports.* Current law authorizes the Secretary to approve, prior to April 1, 1989, State alternative deposition plans (ADP's) designed to relocate nursing facility residents determined, under PASSAR's annual resident review component, to require "specialized services" (see section 4271(c)(11), below), but not to require the level of services provided by a nursing facility. Such plans have been approved by the Secretary for some 47 States. Under the committee bill, each of these States is required to report to the Secretary, on an annual basis, on the number and disposition of the nursing facility residents covered under the State ADP. In addition, the committee intends that the Secretary require States with ADP's in effect to provide information on the age of each individual covered under a State's ADP, the type or types of "specialized services" required by each such individual, and the type of facility or community setting to which each such individual has been (or will be) relocated.

Current law also requires that the Secretary report to Congress, on an annual basis, on the extent of nursing facility compliance with the requirements of OBRA '87 and on the number and type of Federal and State enforcement actions taken under that law. The committee bill provides that the Secretary's annual report also include a summary of the State information (as specified above) on approved ADP's.

(9) *Revision of Alternative Disposition Plans.* Current law does not provide for any revisions in a State's ADP once it has been approved by the Secretary. Under the committee bill, subject to the approval of the Secretary, a State with an approved ADP is authorized to revise or amend, before October 1, 1990, its approved ADP. The Secretary may approve such a revision or amendment, however, only if the revised agreement provides that all residents covered under the agreement who do not require nursing facility services, are discharged from the facility no later than April 1, 1994 (5 years after the initial deadline for filing ADP's). Thus, this provision of the committee bill gives States the opportunity to revise their approved ADP's in light of the information resulting from the first set of annual resident reviews.

(10) *Definition of Mentally Ill.* In establishing the requirements for those individuals who are subject to the PASSAR process, OBRA '87 defined "mentally ill" individuals to *include* those "with a primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental disorders, 3rd edition [DSM III])" and to exclude those with a "primary diagnosis of dementia (including Alzheimer's disease or a related disorder." At the time this definition was developed and adopted by the Congress, there was general agreement that a reference to DSM-III was the most appropriate most widely recognized way to identify the population at risk of inappropriate institutionalization.

Because of it very breadth, however, much confusion has arisen over the implementation of definition of the term "mentally ill". To avoid any further difficulties, the committee bill modifies the definition of mental illness from "a primary or secondary diagnosis of mental disorder (as defined in DSM-III)" to a "serious mental illness as defined by the Secretary". In developing this definition, however, the committee intends that the Secretary refer to the term "serious mental illness" as that term is defined and used in the Community Support Program operated under the National Institute of Mental Health.

The committee notes that in making this modification, there is no intention to include any changes to that part of the OBRA '87 definition of mental illness which excludes individuals with "a primary diagnosis of dementia (including Alzheimer's disease or a related disorder)". Such individuals remain exempt from both aspects of the PASSAR process.

(11) *Substitution of "Specialized Services" for "Active Treatment".* Under OBRA '87, State mental health and mental retardation authorities are not only required to determine if an individual with mental illness or mental retardation requires the level of services provided by a nursing facility; such authorities are also required to determine if these individuals require "active treatment" for these conditions. OBRA '87 defined the term "active treatment" to have the meaning formulated by the Secretary. The law specifically excluded from this definition of "active treatment," however, those services within the scope of services that a nursing facility must provide or arrange for its residents under the OBRA '87 requirements relating to the provision of services and activities.

In response to some confusion that has arisen over the development of an appropriate definition of this term, the committee bill clarifies, that for the purposes of meeting the OBRA '87 PASSAR requirements, the term "active treatment" does not necessarily have the same meaning as it does for the purposes of meeting the Medicaid requirements for intermediate care facilities for the mentally retarded (ICF/MR). Thus, the committee bill substitutes the term "specialized services" for the term "active treatment". As under current law, the term "specialized services" is to be defined by Secretary. And like current law, the Secretary cannot define "specialized services" to include those services within the scope of services that a nursing facility must provide or arrange for its residents under the OBRA '87 requirements relating to the provision of services and activities.

(12) *Effective Dates.* The committee bill provides that, with some exceptions to section 4271(c), all of the amendments with respect to the OBRA '87 PASSAR requirements are to take effect as if they were included in the enactment of OBRA '87. With respect to the amendments made under section 4271(c)(4) (relating to charges applicable in cases of certain Medicaid-eligible individuals); section 4271(c)(5) (relating to delay in application to private pay residents); section 4271(c)(7) (relating to no delegation of authority to conduct screening and reviews); section 4271(c)(9) (relating to revision of alternative disposition plans); and section 4271(c)(11) (relating to substitution of "specialized services" for "active treatment"), the bill provides that those modifications are to take effect on the date of the enactment of this Act, without regard to whether or not regulations to implement these modifications have been promulgated by the Secretary.

(d) *Other Amendments.*

(1) *Assurance of Appropriate Payment Amounts.* As this committee recognized in the report to accompany the House Budget committee's 1987 Budget Reconciliation Amendments, quality nursing home care is not free (H. Rept. 100–391, p. 463). The committee anticipated then—as it does today—that a number of the reforms contained within OBRA '87 will entail additional costs of operation for nursing facilities participating in Medicaid.

In order to assure that Medicaid State payment rates allow for these additional costs, OBRA '87 requires that, for those Medicaid nursing facilities in compliance with the law, such rates must take into account the costs of meeting the statute's requirements relating to the provision of services, residents' rights, and administration. To ensure that State Medicaid payments actually take these costs into consideration, OBRA '87 also requires that each State submit to the Secretary (by April 1, 1990), a State plan amendment to provide for an appropriate adjustment in payment amounts for nursing facility services furnished on or after October 1, 1990. The Secretary is required to review and approve or disapprove each such amendment by September 30, 1989. The failure of the Secretary to approve an amendment, however, does not relieve either the State or any nursing facility of the obligation to comply with requirements of OBRA '87.

The committee bill clarifies that State Medicaid plan amendments must include a detailed description of the State methodology used in determining the appropriate adjustment in the payment amounts for nursing facility services. In addition, the bill specifies that these costs include the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

(2) *Disclosure of Information of Quality Assessment and Assurance Committees.* Under OBRA '87, nursing facilities must establish and maintain a quality assessment and assurance committee designed (i) to identify quality assessment and assurance issues and (ii) to develop and implement appropriate plans of action to correct those quality deficiencies which have been identified. The committee bill clarifies that the internal records of these committees are subject to disclosure only for the purpose of determining whether or not a such a committee is meeting its statutory obligations, and,

consequently, of determining whether a nursing facility is in compliance with this OBRA '87 requirement.

(3) *Period for Resident Assessment.* OBRA '87 requires that a nursing facility conduct a standardized, reproducible assessment of each resident's functional capacity which describes the resident's capability to perform daily life functions as well as any significant impairments in the resident's functional capacity. Such an assessment is to be performed no later than 4 days after the resident's admission. The committee bill extends this period to 14 days.

(4) *Clarification of Responsibility for Services for Mentally Ill and Mentally Retarded Residents.* Under current law, a nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care. In the case of residents with mental illness or mental retardation, however, the provision of, or the arrangement for, some of these services (such as "specialized services" as discussed in section 4271(c)(11), above) may be the responsibility or obligation of the State, not of the nursing facility. The committee bill simply clarifies the lines of responsibility for those residents with mental illness or mental retardation. Thus, for those treatments or services which are required by an individual with mental illness or mental retardation and which the State does not provide or arrange for (or is not required to provide or make arrangements for), the nursing facility itself must provide (or arrange for the provision of) such services.

(5) *Residents' Rights to Refuse Intra-Facility Transfers to Move the Resident to a Medicare-Qualified Portion.* Under the Medicare Catastrophic Coverage Act of 1988 (Public Law 100–360), since January 1, 1989, Medicare coverage for a stay in a skilled nursing facility (SNF) has been expanded to up to 150 days in a calendar year. As a result of this expansion, many Medicaid-eligible nursing facility residents are now also eligible for Medicare SNF services (such residents are often referred to as being "dually-eligible"). In virtually every State, the Medicare reimbursement rate for these services is higher than the State reimbursement rate for similar nursing facility services covered under Medicaid. Consequently, nursing facilities now have an incentive to transfer or relocate their "dually-eligible" residents from their Medicaid-certified beds (for which facilities receive fewer dollars) to their Medicare-certified beds (for which facilities receive more dollars). State Medicaid agencies also have an incentive to encourage nursing facilities to follow this practice since it allows Federal Medicare dollars to be substituted for State and Federal Medicaid funds.

Under current law, however, residents can be transferred or discharged within a nursing facility " . . . only for medical reasons or for his welfare or that of other patients or for non-payment of his stay . . . and is given reasonable advance notice to ensure orderly transfer or discharge and such actions are documented in his medical record" (42 C.F.R. 405.1121(k)(4)). Under this rule, the involuntary transfer of "dually-eligible" residents for the sole purpose of taking advantage of the expanded Medicare SNF benefit is clearly prohibited. Nonetheless, over the past few months, the committee has received disturbing reports about a number of nursing facilities that are involuntarily transferring their "dually-eligible" residents

from their Medicaid-certified beds to their Medicare-certified beds in order to receive a higher Medicare reimbursement rate. These reports further indicate that involuntary transfers of this type have led to confusion, depression, and loneliness among the residents affected.

HCFA has received similar reports and complaints and has recently made its position on this matter clear. In a June 12, 1989 letter to all nursing home administrators (whose facilities are certified under either Medicare or Medicaid, or under both programs), HCFA stated:

> It is clear that an individual cannot be moved except for medical reasons or non-payment. With respect to non-payment under Medicare or Medicaid, you should be aware that an individual cannot simply be moved from either a Medicare bed or from a Medicaid bed because the individual is no longer eligible for the benefit unless you provide them proper notification of their rights under the applicable statute.
>
> Furthermore, a person cannot be required to move from his/her bed into a Medicare certified bed simply to take advantage of the Medicare benefit. Although Medicaid is required under certain circumstances to seek payment for services from other parties, it is not required to mandate transfer of an individual from one place to another to obtain these payments.

HCFA went on in its letter to acknowledge—as this committee does now—the reimbursement dilemma that has arisen in response to the expanded Medicare SNF benefit: a resident must occupy a Medicare-certified bed in order for a facility to receive Medicare payment, but in order to occupy such a bed, a resident may have to be moved, in violation of current law. To avoid this conflict (as well as to begin to implement the OBRA '87 requirement which mandates the elimination of the distinction between the two different types of Medicaid-certified beds), HCFA suggests in its letter that facilities consider having all their beds "dually-certified" at the SNF level. The committee concurs in this view. In the intervening time, however, the committee expects the Secretary to continue to enforce current law regarding residents' transfer rights as specified in 42 C.F.R. 405.1121(k)(4), quoted above.

Nonetheless, to ensure that these rights are protected under OBRA '87, the committee bill establishes the right of a resident to refuse a transfer to another room within the facility if a purpose of the transfer is to relocate the resident from a non-Medicare-certified portion of the facility to a Medicare-certified portion of the facility. The committee stresses that the relocation of a resident to a Medicare-certified portion of the facility need not be the sole purpose for the transfer to trigger the resident's right; the relocation for the higher Medicare payment need only be one of the reasons for the move.

If a resident refuses such a transfer, the committee bill further provides that neither the resident's eligibility for Medicaid nor the State's entitlement to Medicaid Federal matching payments is af-

fected. Thus, a resident who refuses such a transfer may, under the committee's bill, remain in his or her current bed location and continue to be eligible for Medicaid services. If that bed is (or ever becomes) Medicare-certified or "dually-certified," however, the nursing facility would be able to receive the Medicare reimbursement rate for the services provided.

(6) *Resident Access to Clinical Records.* OBRA '87 established a number of "residents' rights" that nursing facilities must meet in order to be in compliance with the requirements of the law. Among these is the right to confidentiality of personal and clinical records. The committee bill adds to this provision the right of residents to have prompt access, upon request, to their current clinical records. Such request need not be in writing.

(7) *Inclusion of State Notice of Rights in Facility Notice of Rights.* Among the "residents' rights" established under OBRA '87 is the requirement that nursing facilities make available to each resident, upon reasonable request, a written statement of the resident's legal rights during his or her stay at the facility and of the requirements and procedures for establishing Medicaid eligibility. The committee bill adds to this provision a requirement that a nursing facility's statement include any written notice, prepared by the State under the requirements of OBRA '87, of the rights and obligations of residents (and their spouses) under the Medicaid program.

(8) *Removal of Duplicative Requirement for Qualifications of Nursing Facility Administrators.* Current Medicaid law provides that a State Medicaid plan must include a program which meets specified requirements for the licensing of nursing facility administrators. Under OBRA '87, however, nursing facility administrators are not required to be licensed; instead they are required to meet standards set by the Secretary. The committee bill repeals, effective October 1, 1990, the current Medicaid provisions relating to nursing facility administrators.

(9) *Clarification on Findings of Neglect.* Under OBRA '87, States are required (through their agencies responsible for surveys and certifications of nursing facilities) to review, investigate, and make findings with respect to allegations of neglect or abuse of a resident, or of misappropriation of a resident's property, which are brought against a nurse aide or other individual used by a nursing facility to provide services to such a resident. States are also required to notify the appropriate State authority if a nurse aide or other individual is found to have neglected or abused a resident or to have misappropriated resident property in a nursing facility.

Under the committee bill, however, a State is prohibited from making a finding that an individual has neglected a resident if the individual can demonstrate that such neglect was caused by factors beyond his or her control. Thus, under this standard, a nurse aide (or other individuals used to provide services to residents) cannot be found to have "neglected" a resident if, for example, he or she can demonstrate that the reason a meal went undelivered was because no food was available, rather than because of an unwillingness to deliver the meal. Similarly, a nurse aide cannot be found to have "neglected" a resident if he or she can demonstrate that, at the time a resident needed to be turned in bed, he or she was re-

quired to provide, because of a shortage of personnel, more urgent health-related services to other residents.

In the committee's view, nurse aides and other individuals who provide nursing facility services to residents should not be used as "scapegoats" for those who may have either the responsibility or capability of preventing or correcting the deficiencies that have resulted in charges of resident neglect. Thus, the purpose of this standard is to help ensure that such individuals are not held responsible for actions and activities (such as a shortage of staff, or a shortage of supplies such as dressings, linens, and food) which such individuals can demonstrate are beyond their control.

(10) *Timing of Public Disclosure of Survey Results.* Under OBRA '87, each State and the Secretary must make available to the public, information relating to all surveys and certifications (including statements of deficiencies and plans of correction) respecting nursing facilities. The committee's bill clarifies that the results of such surveys must be made available to the public within 14 calendar days of the time they are made available to the nursing facilities that have been surveyed.

(11) *Clarification of Applicability of Enforcement Rules to Dually-Certified Facilities.* In order to coordinate the Federal and State enforcement efforts established under OBRA '87 to maximize nursing facility compliance with the requirements for Medicaid participation, current law requires that specified rules, designed to delineate which such efforts take priority under what circumstances, be followed. These rules describe the conditions under which the Secretary's or a State's compliance action will take precedence, as well as the circumstances under which the Secretary's or a State's recommendation for sanctions will be applied.

OBRA '87 also established enforcement procedures that are to be applied with respect to skilled nursing facilities participating in Medicare.

OBRA '87 did not, however, address specifically, the procedures and process by which enforcement actions are to be taken against nursing facilities that are certified to participate in both Medicaid and Medicare (such facilities are often referred to being "dually-certified"). To clarify what enforcement rules are to be used in these circumstances, the committee bill requires that the OBRA '87 enforcement requirements relating to nursing facilities participating in Medicaid also apply to facilities participating in both Medicaid and Medicare.

(12) *Clarification of Federal Matching Rate for Survey and Certification Activities.* To assist States in meeting the costs of implementing the new nursing facility survey and certification requirements established under OBRA '87, that law provided for an increase in the Federal matching rate for State survey and certification activities, beginning with fiscal year 1991. The committee bill clarifies that until that time (October 1, 1990), the Federal Medicaid matching rate for these activities is the current 75 percent.

(13) *Miscellaneous Technical Corrections.* The committee bill makes a number of miscellaneous technical corrections to OBRA '87.

(14) *Effective Dates.* The committee bill provides that, except for the provisions relating to sections 4271(d)(8) and 4271(d)(11), all of

the additional amendments made to the OBRA '87 nursing home reform requirements are to take effect as if they were included in the enactment of OBRA '87. With respect to the amendments made under section 4271(d)(8) (relating to removal of duplicative requirement for qualifications of nursing facility administrators), the bill provides that such modifications are to take effective October 1, 1990. With respect to the amendments made under section 4271(d)(11) (relating to clarification of applicability of enforcement rules to "dually-certified" facilities), the bill provides that such modifications are to take effect on the date of the enactment of this Act.

Sec. 4272—Medicare Buy-in Provisions

(a) *Medicare Buy-in for Premiums of Certain Working Disabled.* Under current law, States are required to extend Medicaid coverage to certain working disabled individuals who (1) were eligible for benefits under both Supplemental Security Income (SSI) and Medicaid, (2) due to earnings lost eligibility for SSI, (3) continue to meet the SSI resource test, (4) do not have earnings sufficient to make up for the loss of SSI, Medicaid, and attendant care services, and (5) would be seriously inhibited from continuing employment in the absence of Medicaid benefits. These qualified severely impaired individuals are entitled to full Medicaid benefits so long as they continue to work and meet these requirements.

Under section 10112 of this bill, as reported by the Committee on Ways and Means, Social Security Disability Insurance (SSDI) beneficiaries would be allowed to purchase Medicare coverage after they have worked a full 48 months and have exhausted their extended period of Medicare eligibility. The committee bill would require States to pay the Medicare Part A and Part B premiums (but not deductibles or coinsurance) on behalf of these qualified working and disabled individuals if they are not otherwise eligible for Medicaid and if their income (as determined using SSI methodologies) does not exceed 200 percent of the Federal poverty level ($11,960 for a single individual in 1989). These qualified working and disabled individuals would not be subject to a resource test. States would have the option to impose a sliding scale premium (in reasonable increments, as determined by the Secretary) on those qualified working and disabled individuals whose incomes exceed 150 percent of the poverty level. This requirement is effective July 1, 1990.

(b) *Technical Corrections to Medicare Buy-in For the Elderly.*

Under current law, States are required to pay the premiums, deductibles, and coinsurance for elderly and disabled Medicare beneficiaries with incomes at or below 100 percent of the Federal poverty level ($5,980 for an individual, $8,020 for a family of 2 in 1989) and resources that do not exceed twice the SSI level ($4,000 for an individual, $6,000 for a couple in 1989). This requirement is being phased in over 4 years; in most States, the 1989 minimum income threshold is 85 percent of poverty ($5,083 for an individual, $6,817 for a family of 2 in 1989). The purpose of the Medicare buy-in requirement is to protect the low-income elderly and disabled against increasingly burdensome Medicare cost-sharing obligations.

(1) *Temporary Retroactive Benefits Caused by Delay in Implementation.* The Medicare buy-in protections were effective January 1, 1989. However, according to a March, 1989, report commissioned by the Villers Foundation, only 11 States implemented coverage in January, and only 34 States had implemented coverage by March. In addition, 3 States were reported to be "undecided" as to when to implement. The committee finds these results deeply disturbing, since those who bear the consequences of these lackadaisical compliance efforts are the low income elderly and disabled. The committee expects that this sorry performance, for which both HCFA and the States share responsibility, will not be repeated.

Under the committee bill, States would have the option to make low-income Medicare beneficiaries whole for the losses resulting from delays in implementation of the buy-in protections. If, during the period January through September, 1989, an individual was determined to be a qualified Medicare beneficiary, the State may elect to provide buy-in coverage to the individual for any month during that period, if the individual would have been eligible in that month as a qualified Medicare beneficiary. For example, if a State did not begin taking applications for Medicare buy-in until July, 1989, and an individual was determined to be qualified Medicare beneficiary in that month (and would, given the opportunity to apply, have been a qualified Medicare beneficiary during all of 1989), the State may pay the Medicare premiums, deductibles, and coinsurance for that individual for the months from January through June, 1989, and receive Federal Medicaid matching funds for those costs.

(2) *Clarification with Respect to "Section 209(b)" States.* Under current law, qualified Medicare beneficiaries are, like Medicare beneficiaries, defined as a national class, with uniform eligibility criteria. The income standard is specified as a percentage of the Federal poverty level. The resource standard is set at twice the SSI level. Both income and resources are determined using SSI methodologies or, at State option, less restrictive methodologies. These criteria apply in all States, including "209(b)" States, which apply eligibility standards to aged, blind, or disabled individuals more restrictive than those under SSI in determining eligibility for Medicaid.

HCFA has taken the view that "if you are a 209(b) State, you may apply your more restrictive income methodologies in determining eligibility under this provision. You may also use your more restrictive resource standards and methodologies in determining eligibility under this provision." *State Medicaid Manual Transmittal #31* (December, 1988). This interpretation of the statute is in error, and the committee bill would so clarify. "209(b)" States may not (and have never had the authority to) use their more restrictive income methodologies or their more restrictive resource standards or methodologies in determining eligibility for qualified Medicare beneficiaries.

Sec. 4273—State Matching Payments Through Voluntary Contributions and Taxes

(a) *Voluntary Contributions.* Under current regulations, 42 C.F.R. 433.45, States are allowed to use as State expenditures, for pur-

poses of receiving Federal Medicaid matching payments, funds donated from private sources that (1) are transferred to the State Medicaid agency and are under that agency's administrative control, and (2) do not revert to the donor's facility or use unless the donor is a non-profit organization and the Medicaid agency, of its own volition, decides to use the donor's facility. In testimony submitted for the record at a hearing of the Subcommittee on Health and the Environment on June 8, 1989, HCFA stated its intent to undertake a regulatory initiative to limit the use of donations as the State share of Medicaid. Section 8431 of the Technical and Miscellaneous Revenue Act of 1988 (Public Law 100-647), imposed a moratorium on the issuance of any final regulation changing the treatment of voluntary contributions used by States to receive Federal Medicaid matching funds; this moratorium expired on May 1, 1989.

In Tennessee, the Volunteer State, funds donated by nonprofit hospitals have enabled the State to extend Medicaid coverage to low-income pregnant women and infants with incomes up to 100 percent of the Federal poverty level, to increase the scope of the inpatient hospital benefit for all Medicaid eligibles from 14 to 20 days, and to provide a payment adjustment to disproportionate share hospitals. The committee notes with approval the recent decision of the Departmental Appeals Board upholding Tennessee's donated funds policy and rejecting the efforts of HCFA to disallow Federal Medicaid matching funds to the State for its use of these funds. *Tennessee Department of Health and Environment,* DAB No. 1047 (May 4, 1989).

In the view of the committee, the use of donated funds by Tennessee and other States to pay the State share for expansion of Medicaid eligibility or services, or for increased reimbursement to disproportionate share hospitals, is entirely appropriate. Applied in this manner, donated funds promote the basic objective of the Medicaid program—to make quality health care accessible to the poor. In order to facilitate such arrangements, the committee bill would allow States to use private funds donated by hospitals to the State, and subject to its unrestricted control, as State expenditures for purposes of receiving Federal Medicaid matching funds. The State's authority to use donated funds to claim Federal matching funds would be subject to the following limitations: (1) the aggregate amount of donations in any Federal fiscal year could not exceed 10 percent of the State's share of aggregate Medicaid expenditures in that State for that year, and (2) the aggregate amount of donations made by (or on behalf of, or with respect to) any particular hospital in an annual cost reporting period could not exceed 10 percent of the hospital's gross revenue (excluding any Federal funds under Medicaid, Medicare, or the Title V Maternal and Child Health Block Grant). The committee bill is effective for funds donated on or after May 1, 1989.

Under the committee bill, hospitals may benefit from a donation of funds. For example, if a hospital primarily serves children, and a State uses the funds voluntarily contributed by the hospital and other hospitals to expand Medicaid eligibility for poor children, and some of the newly-eligible children use the hospital's services, the fact that the hospital has received Medicaid reimbursement for

services rendered to these children does not invalidate the hospital's contributions as a permissible donation. Or, for example, if a hospital is a Medicaid disproportionate share hospital, and a State uses funds voluntarily contributed by that hospital and other disproportionate share hospitals to expand Medicaid eligibility and to comply with the statutory requirement that it make a payment adjustment to disproportionate share hospitals, the fact that the hospital, like other disproportionate share hospitals, receives an increase in its reimbursement for the Medicaid patients it serves does not disqualify its contributions as donations.

However, under the committee bill, if the amount of the benefit to the hospital is directly related, in timing and amount, to the timing and amount of the transfer, the transfer would not be considered a donation. For example, if a hospital is the only facility in a given reimbursement category under the State's Medicaid plan, and the State uses the funds transferred by the hospital to increase the reimbursement rate solely to that hospital's category, and the amount by which the rate increases is directly related to the amount of the funds transferred by the hospital, the transfer of funds could not be treated as a donation.

The committee emphasizes that, in order to qualify as State expenditures for Federal Medicaid matching purposes, the donations must be voluntary, and, once made, must be under the unrestricted control of the State. It is not the intent of the committee bill to legitimize donations that are made under circumstances that are inherently coercive and abusive. For example, a State that provides preferential treatment and increased interim funding in order to induce fund transfers from hospitals, and then uses those funds as the State share for a substantial backlog of pending claims from those hospitals, would not meet the requirements of the committee bill. A fact situation of this nature was described by the Departmental Appeal Board in *West Virginia Dept. of Human Services,* DAB No. 956 (1988), rev'd, *Lipscomb* v. *Sullivan,* C.A. 2: 87-0333 (S.D.W.V., June 28, 1989).

The committee further notes that the Texas Department of Human Services has placed 140 staff at over 60 hospitals and clinics throughout the State to process applications for Medicaid. For purposes of Federal financial participation, the facilities pay the State's share of the administrative costs of this staff, an amount estimated by the State at about $1.3 million for fiscal year 1989. In the case of private facilities, for purposes of the committee bill, these payments for State staff would constitute funds donated by hospitals to, and subject to the unrestricted control of, the State. Texas could continue its current practice of claiming Federal Medicaid matching funds for these expenditures.

(b) *State Tax Contributions.* The Medicaid statute does not specify the revenue sources from which States may finance their expenditures under the Medicaid program. Income taxes, sales taxes, excise taxes, and property taxes are revenue sources used by many States.

Some States, such as Florida, Tennessee, and Texas, also impose taxes or other mandatory assessments (such as licensure fees) on health care providers or classes of providers (e.g., all hospitals, only disproportionate share hospitals, only district or university hospi-

tals). In some instances, these taxes or other assessments are applied at a uniform rate among providers. In other cases, they are structured to "level the playing field" among providers by imposing a relatively higher burden on facilities which provide relatively lower amounts of indigent care. In some cases, these taxes and assessments are permanent. In other instances, these taxes are temporary, as when Maine in 1988 imposed a one-time excise tax on hospitals to initiate eligibility expansions for pregnant women and infants and the elderly and disabled. Revenues from these provider-specific taxes or other assessments have been used to fund State indigent care programs, to fund expansions in Medicaid eligibility or services, or to free up revenues from other sources for the funding of such programs or expansions.

In testimony submitted for the record at a hearing of the Subcommittee on Health and the Environment on June 8, 1989, HCFA stated its intent to undertake a regulatory initiative to limit the use of provider-specific taxes as the State share of Medicaid spending. A moratorium on the issuance of any final regulation changing the treatment of provider-specific taxes used by States to receive Federal Medicaid matching funds, contained in section 8431 of the Technical and Miscellaneous Revenue Act of 1988 (Public Law 100–647), expired on May 1, 1989. In the view of the committee, HCFA does not have, and never had, the authority to dictate to the States what tax or mandatory assessment mechanisms they may use in order to raise revenues that will pay for State Medicaid expenditures.

It is evident that States need revenues in order to implement expansions in their Medicaid programs such as those required by sections 4201 and 4211 of the bill. The committee believes that the use of provider-specific taxes or other mandatory assessments is an appropriate method for States to finance the expansion of Medicaid eligibility or services for the poor. The committee bill would therefore clarify that nothing in the Medicaid statute may be construed to authorize the Secretary to deny or limit payments to a State for Medicaid expenditures attributable to taxes, whether or not of general applicability, imposed with respect to the provision of items or services. The committee specifically intends that, for this purpose, the term "taxes" include licensure fees and any other mandatory assessments that a State may elect to impose on health care providers.

Sec. 4274—Disproportionate Share Hospitals

Under current law, States are required, in making payment for inpatient hospital services, to take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs. In response to widespread noncompliance with this requirement, section 4112 of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203) set forth minimum criteria for defining disproportionate share hospitals and for payment adjustments States are required to make. In computing payment adjustments for disproportionate share hospitals, States may use (1) the Medicare disproportionate share adjustment percentage, or (2) an alternate methodology that provides for an additional payment amount or increased percentage payment. This requirement is

being phased in over a 3 year period and will be fully implemented by July 1, 1990.

A survey conducted by the Intergovernmental Health Policy Project in February, 1989, for the National Association of Public Hospitals found that (1) only 6 States (California, Florida, Louisiana, Michigan, New York, and Tennessee) account for nearly two-thirds of total Medicaid spending for disproportionate share payments; (2) a total of 14 States have proposed no better than *de minimis* payment adjustments (some as low as $1 per day); (3) average payments per hospital range from a high of $2.6 million in Louisiana to $0 in several States); and (4) less than half of the State plan amendments submitted to comply with the OBRA 1987 requirements have been approved by HCFA. The committee is seriously concerned by the delays in implementation of the disproportionate share hospital requirements and, in particular, by the inadequate payment adjustments that persist in some States. The committee expects HCFA to scrutinize State reimbursement policies toward disproportionate share hospitals and assure that all of the States are in compliance with the statutory requirements and that reimbursement rates more adequately reflect hospital costs. The committee will continue to monitor closely the implementation of this requirement and, if necessary, will consider the imposition of a uniform national standard for the payment adjustment.

(a) *Clarification of Medicaid Disproportionate Share Adjustment Calculation.* The committee bill would clarify that, for purposes of calculating a hospital's Medicaid inpatient utilization rate, an inpatient day includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere. The intent of the committee is to make clear that States must include all Medicaid inpatient days, including a hospital's nursery, psychiatric, and administrative Medicaid patient days, in calculating a hospital's Medicaid inpatient utilization rate for purposes of determining eligibility for, and the amount of, payment adjustments to Medicaid disproportionate share hospitals. The provision would take effect on July 1, 1990.

(b) *Federal Financial Participation for Medicaid Capital Payments.* The committee bill would clarify that the Secretary is, and has since 1981 been, without authority to limit the amount of payment adjustments, including pass-through payments for capital costs, that may be made under a State's Medicaid plan to disproportionate share hospitals. It is the intent of the committee that States such as California which elect to make capital pass-through payments to disproportionate share hospitals qualify for Federal financial participation in connection with these expenditures.

(c) *Special Rule for New Jersey Uncompensated Care Trust Fund.* Current law establishes a special rule by which two States, New York and Texas, can comply with the requirement that payments for inpatient hospital services take into account the situation of disproportionate share hospitals. The committee bill would establish a special rule for the New Jersey Uncompensated Care Trust Fund. The bill identifies New Jersey as a State with a Medicaid plan that, as of January 1, 1987, provided for payment adjustments

based on a statewide pooling arrangement involving all acute care hospitals which provides for reimbursement of the total amount of uncompensated care delivered by each participating hospital. Under the bill, New Jersey would be in compliance if the aggregate amount of the payment adjustments under its Medicaid plan for disproportionate share hospitals is not less than the aggregate amount of such adjustments otherwise required to be made under the Medicaid statute. The provision is effective as though enacted in OBRA '87.

Sec. 4275—Medicaid Provisions Relating to Demonstration of Effectiveness of Minnesota Family Investment Plan

Section 10265 of this bill, as reported by the Committee on Ways and Means, would authorize a demonstration of the Minnesota Family Investment Plan. The committee bill would provide that, if the Secretary approves this demonstration, Federal Medicaid matching payments would be available for the costs of services and administration for families participating in the demonstration. To ensure budget neutrality, the bill limits the aggregate amount of the Federal matching payments to the amount that would have been made for participating families in the absence of the demonstration. The State would be required to (1) provide Medicaid benefits to all families participating in the project, (2) provide Medicaid 12-month transitional coverage to all families whose participation is terminated due to increased income from employment, and (3) provide Medicaid 12-month extension coverage to all families whose participation is terminated due to the collection or increased collection of child support. The committee bill does not authorize the Secretary to waive any requirement of Title XIX in connection with this demonstration, and the committee does not intend that the demonstration result in the reduction of eligibility or coverage under current law to Medicaid beneficiaries in Minnesota.

Sec. 4276—Miscellaneous Provisions

(a) *Fraud and Abuse Technical Amendments*

(1) *Treatment of Loss of Right to Renew License.* Under current law, the Secretary is permitted to exclude from Medicare and State health care programs, including Medicaid, individuals and entities whose license to practice has been revoked, suspended, or "otherwise lost." The committee is informed that, in reviewing State licensure board actions to determine whether exclusion is appropriate, the Inspector General has found a number of cases in which a board has revoked the "license" of a physician whose actual license had already expired, or in which a board has revoked the right of a physician to renew a license which has expired. The committee bill would clarify that the loss of a right to apply for or renew a license to provide health care is tantamount to losing the license itself and may serve as the basis for exclusion from Medicare and State health care programs.

(2) *Clarification with Respect to Emergency Treatment.* Under current law, payments may not be made under Medicare or State health care programs (including Medicaid) for items or services (other than an emergency item or service) furnished by individuals or entities excluded from participation in the programs during the

period of the exclusion. The purpose of the exception for emergency items or services is to assure that program beneficiaries have immediate access to emergency care when needed, even if the nearest physician has been excluded from the program. The committee is informed that the Inspector General has identified cases in which excluded physicians are practicing on a full-time basis as "emergency physicians" in hospital emergency rooms and continuing to receive payments under Medicare and Medicaid for the services they routinely provide there. In the view of the committee, this behavior is designed to circumvent the intent of the prohibition on payments to excluded practitioners and represents a clear abuse of the emergency item or service exception. The committee bill would therefore clarify that payments may not be made to excluded physicians or other individuals or entities for items or services furnished in an emergency room of a hospital.

(b) *Psychiatric Hospitals*

(1) *Clarification of Coverage of Inpatient Psychiatric Hospital Services.* Under current law, States may offer Medicaid coverage for inpatient psychiatric hospital services for individuals under 21. These are defined by statute as inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital as defined in section 1861(f) of the Social Security Act. Current regulations, 42 C.F.R. 441.151(b) also allow the provision of such services in nonhospital settings. They recognize services provided by a psychiatric facility or an inpatient program in a psychiatric facility, either of which is accredited by the Joint Commission on Accreditation of Hospitals. The committee bill would clarify that inpatient psychiatric hospital services may be provided in either a psychiatric hospital or in another inpatient setting that the Secretary has specified in regulations. This provision is effective as though enacted in the Deficit Reduction Act of 1984 (Public Law 98-369), when the statute was inadvertently amended in a manner seemingly inconsistent with current HCFA regulations and policy.

(2) *Intermediate Sanctions for Psychiatric Hospitals.* Under current law, psychiatric hospitals that are not in compliance with the conditions of participation are subject to termination from the Medicaid program. Neither the State nor the Secretary has authority to impose intermediate sanctions in such circumstances.

Under the committee bill, termination would remain the only sanction available to a State if the State determines that a psychiatric hospital's deficiencies immediately jeopardize the health and safety of its patients. However, if the deficiencies do not immediately jeopardize patient health or safety, the State would have a choice of terminating participation by the hospital or denying Medicaid payment for patients admitted after the date of the findings. The Secretary would be authorized to continue Federal Medicaid matching payments for services at the noncomplying facility for a period of up to 6 months from the date of the findings, but only if (1) the State elects not to terminate the facility's participation, (2) the State submits a plan and timetable for corrective action and the Secretary approves the plan, and (3) the State agrees to repay any Federal Government funds paid to the facility if corrective action is not taken in accordance with the approved plan and time-

table. Under the committee bill, the State would be required to deny Medicaid payments for all new admissions if the facility remains out of compliance for 3 months from the date of the findings, whether or not the facility is operating under a corrective action plan. If the hospital remains out of compliance for 6 months from the date of the findings, no Federal Medicaid matching payments would be available for services provided by the facility until the State determines that the hospital is in compliance.

(c) *Clarification of Application of 133 Percent Income Limit to Medically Needy.* Under current law, States may extend Medicaid coverage to individuals who meet the categorical requirements for eligibility (i.e., they are aged, blind, disabled, or members of a family with dependent children), but who are not receiving cash assistance under AFDC or SSI because they do not meet the income or resource standards. Individuals qualify for coverage as medically needy when their incomes, less incurred medical expenses, meet the State's medically needy income level (MNIL). The State may not set its MNIL higher than 133⅓ percent of the payment standard for an AFDC family of comparable size. HCFA has erroneously attempted to apply the 133⅓ percent ceiling to optional categorically needy groups who are not receiving cash assistance. The committee bill would clarify that the 133⅓ percent limit applies, and has always applied, solely to determinations of eligibility with respect to medically needy individuals.

Under current law, States, in determining income and resource eligibility for certain eligibility groups consisting of aged, blind, or disabled individuals, may not use methodologies that are more restrictive, and may use methodologies that are less restrictive, than the methodology used under the Supplemental Security Income (SSI) program. This provision, by its own terms, applies to aged, blind, or disabled individuals in "section 209(b)" States that have opted to use eligibility criteria (in their January, 1972 State plans) more restrictive than those under SSI. These States may still set eligibility standards lower than those under SSI, but may not use methodologies that are more restrictive than those under SSI.

The committee bill would further clarify that "209(b)" States may not use income or resource methodologies in determining eligibility for aged, blind, or disabled individuals that are more restrictive than those under SSI. Under current law, a methodology is considered "no more restrictive" if, using the methodology, additional individuals may be eligible for Medicaid and no individuals who are otherwise eligible are made ineligible. For example, under current law, in determining a disabled child's eligibility for SSI benefits, the Social Security Disability Income (SSDI) benefits of the father are not attributed to the child. A "209(b)" State could not count the father's SSDI benefits in determining whether the SSI-eligible child qualifies for Medicaid, because this methodology would result in the denial of Medicaid eligibility to the child.

(d) *Health Maintenance Organizations (HMO's)*

(1) *Waiver of 75 Percent Rule for Public Entities.* Under current law, no Federal Medicaid matching payments may be made for services provided by entities contracting with States on a prepaid capitation or other risk basis if 75 percent or more of the enrollees are Medicaid or Medicare beneficiaries. The Secretary may modify

or waive this requirement in the case of an HMO that is a public entity if (1) special circumstances warrant the modification or waiver and (2) the HMO has taken and is taking reasonable efforts to enroll individuals who are not eligible for Medicaid or Medicare. The committee bill would delete the requirement that the Secretary find special circumstances warrant the modification or waiver.

(2) *Extending Special Treatment to Medicare Competitive Medical Plans (CMP's).* Under current law, States have the option to guarantee to certain HMO's a minimum enrollment period of up to 6 months for Medicaid beneficiaries who lose eligibility for benefits during the period. The committee bill would add Medicare CMP's to the types of HMO's to which States may extend this minimum enrollment protection. In addition, States may currently deny Medicaid beneficiaries their right to disenroll from certain HMO's without cause for up to 6 months. The committee bill would include Medicare CMP's among the types of HMO's into which Medicaid beneficiaries could be "locked" for up to 6 months.

(3) *Automatic 1-Month Reenrollment for Short Periods of Ineligibility.* Under current law, if a Medicaid beneficiary who is enrolled in an HMO loses eligibility due to a short-term change in income or resources, upon reestablishing eligibility the individual is not automatically reenrolled in the HMO. Given the high turnover rates in the Medicaid caseloads in many States, this creates a substantial disincentive for HMO's to enroll Medicaid beneficiaries. The committee bill would therefore allow States, at their option, to reenroll individuals who lose and quickly reestablish eligibility in the following circumstances: (1) the individual must be enrolled as Medicaid beneficiary in an HMO; (2) the individual must lose eligibility for Medicaid while enrolled; (3) the individual must reestablish eligibility for Medicaid in the first month or the second month after losing eligibility; and (4) the individual must be reenrolled (if the State elects this option) in the same HMO. The committee bill is intended to minimize the administrative disruption to HMO's resulting from the involuntary loss of eligibility by Medicaid beneficiaries. It is not intended to lock beneficiaries into HMO's. Upon reenrollment, the individual would have the same right to disenroll without cause upon 1 months' notice applied before the loss of eligibility.

(4) *Elimination of Provisional Qualification for HMO's.* The committee bill would strike an obsolete authority for States to make a provisional determination as to whether an HMO is Federally qualified.

(e) *Personal Care Services.* Under current law, States have the option of offering Medicaid coverage for any medical or remedial care specified by the Secretary. By regulation, the Secretary has specified personal care services in a beneficiary's home, defined as services prescribed by a physician in accordance with the beneficiary's plan of treatment and provided by an individual who is qualified to provide the services, supervised by a registered nurse, and not a member of the beneficiary's family. It has come to the attention of the committee that HCFA is attempting to limit the scope of personal care services to services delivered within the beneficiary's home.

HCFA's interpretation would preclude a State, in the case of a ventilator-dependent beneficiary who requires periodic suctioning, from using Medicaid funds to pay for the services of an attendant whenever that beneficiary is outside of his home. The effect is to severely limit the beneficiary's ability to live a normal life and, in some cases, to live in the community at all. In the view of the committee, the HCFA interpretation is inconsistent with one of the broad purposes of the Medicaid program, to encourage the independence and integration into the community of low-income elderly and disabled individuals.

The committee bill would therefore establish an optional benefit, personal care services, and define it to mean services (1) prescribed by a physician for an individual in accordance with a plan of treatment, (2) provided by a person who is qualified to provide such services and is not a member of the individual's family, (3) supervised by a registered nurse, and (4) furnished in a home or other location. Personal care services would not include services furnished to an inpatient or resident of a hospital or nursing facility. The committee bill would take effect on enactment and would apply to personal care services furnished before enactment under 42 C.F.R. 440.170(f). The committee's intent is to nullify HCFA's interpretation of current regulations that personal care services must be performed solely in the beneficiary's home, as well as to clarify that HCFA may not impose such a restriction on the personal care services benefit in the future.

The committee observes that, under section 4251 of the committee bill, States would have the option to offer community care to functionally disabled elderly individuals. Community care would include a number of different services, one of which is personal care services. The committee emphasizes that personal care services offered by States under the option defined by this provision of the bill ((c)section 4276(e)) would not be subject to the same requirements that would apply to personal care services offered by States under the community care option. For example, under the community care option, services are limited to functionally disabled elderly individuals. Under the free-standing option, personal care services could be offered to both elderly and non-elderly individuals, whether functionally disabled or not. The same observation applies with respect to personal attendant care, one of the "core" elements of the optional community habilitation and supportive services benefit that would be established by section 4221 of the committee bill. The requirements applicable to personal attendant care under section 4221 would not apply to personal care services under this section.

(f) *Supervision of Health Care of Residents of Nursing Facilities by Nurse Practitioners and Clinical Nurse Specialists Acting in Collaboration with Physicians.* Under current law, skilled nursing facilities (SNF's) participating in Medicaid must have a policy that the health care of every resident is under the supervision of a physician, and that the physician visit the patient at least once every 30 days during the first 90 days after admission, and no less frequently than once every 60 days thereafter. Intermediate care facilities (ICF's) participating in Medicaid must ensure that the health care of each resident is under the continuing supervision of

a physician, and that the physician see the resident whenever necessary, but at least once every 60 days, unless the physician decides that visits of that frequency are unnecessary and records the reasons for that decision. These physician visit requirements are independent of the physician certification requirements applicable to all Medicaid-eligible residents in SNF's or ICF's.

Under the nursing home reform provisions contained in the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203), effective October 1, 1990, nursing facilities must require that the health care of every resident be provided under the supervision of a physician. As under current law, this supervision would include periodic visits to each resident. Under current law, States may pay for care provided by licensed practitioners, including nurse practitioners and clinical nurse specialists, within the scope of their practice as defined by State law. The committee bill would give States the option of paying nurse practitioners or clinical nurse specialists working in collaboration with a physician to conduct these periodic visits to nursing facility residents, but only if the practitioner or specialist is not an employee of the facility in which the beneficiary resides. The committee does not intend to restrict in any way the right of residents to choose a personal attending physician, or the freedom of Medicaid beneficiaries to choose a nurse practitioner or clinical nurse specialist. This option is effective October 1, 1990, without regard to whether final implementing regulations have been promulgated.

(g) *Codification of Coverage of Rehabilitation Services.* Under current law, States may offer Medicaid coverage for other diagnostic, screening, preventive, and rehabilitative services. By regulation, 42 C.F.R. 440.130(d), the Secretary has defined rehabilitative services to include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level. The committee is informed that currently 14 States have elected, under this optional service, to provide mental health rehabilitation services to individuals with severe and long-term mental illnesses (Arkansas, Florida, Idaho, Maine, New Hampshire, New York, North Carolina, Ohio, Oregon, Rhode Island, South Carolina, South Dakota, Vermont, and Wisconsin). The committee bill would codify the current regulation, effective on enactment.

(h) *Institutions for Mental Diseases.*

(1) *Study.* Under current law, the Federal Medicaid matching funds are not available for services to individuals under the age of 65 who are patients in an institution for mental diseases (IMD). The statute defines an IMD as a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases. The Secretary in regulation, 42 C.F.R. 435.1009, has provided that classification of an institution as an IMD is determined by its "overall character." Under guidelines developed by HCFA, one of the tests for identifying a facility as an IMD is whether more than 50 percent of all the patients in the facility have mental diseases requiring inpatient treatment. For a single facility, under a

common administration, containing a number of different units serving patients with different needs and each with a separate license, a central issue is whether to include the beds of all the patients when determining the facility meets the 50 percent test. Changes in the way that mental health care is delivered have left a number of "mixed purpose" facilities unclear as to their IMD status, and the way in which it is determined.

The committee bill would require the Secretary to conduct a study of the implementation of the exclusion of coverage for services to individuals under 65 residing in IMD's. On the basis of this study, the Secretary would be required to submit to Congress a report that includes any recommendations for modification in the current Medicaid provisions, regulations, guidelines, and practices that may be appropriate to accommodate changes that may have occurred in the delivery of psychiatric and other mental health services on an inpatient basis since the IMD exclusion was enacted in 1972. The report is due by October 1, 1990.

(2) *Moratorium on Treatment of Certain Facilities.* The committee bill would provide that any determination by the Secretary that Kent Community Hospital Complex or Saginaw Community Hospital (both in Michigan) is an IMD shall not take effect until 180 days after Congress receives the report described above.

(3) *Subacute Psychiatric Facilities.* Under current law, States may offer Medicaid coverage for inpatient psychiatric hospital services to individuals under age 21, and for services in IMD's for individuals 65 and over. The committee bill would direct the Secretary to conduct a study of the costs and benefits of providing Medicaid services in public subacute psychiatric facilities which provide services to psychiatric patients who would otherwise require acute hospitalization. The study must examine, with respect to individuals under 21 and over 64, (1) the relative difference in the cost of providing services in subacute psychiatric facilities and acute inpatient psychiatric facilities, (2) the effect of subacute psychiatric facilities in preventing hospitalization in acute psychiatric facilities, and (3) the impact of subacute psychiatric facilities on the accessibility and quality of psychiatric services. The report must be submitted to the Congress by October 1, 1990. The committee expects that, in connection with this report, the Secretary will study the cost-effectiveness, accessibility, and quality of services at the East Valley Pavilion of the Santa Clara Valley Medical Center in San Jose, California.

(i) *Timely Payment Under Waivers of Freedom of Choice of Hospital Services.* Under current law, States must have claims payment procedures that ensure that 90 percent of the clean claims (i.e., those not requiring further information or substantiation) submitted by physicians and other health care practitioners are paid within 30 days of receipt, and that 99 percent of such claims are paid within 90 days of receipt. Current law also entitles Medicaid beneficiaries to freedom of choice among providers electing to participate in the program. However, the Secretary is authorized to waive certain requirements, including the freedom of choice protection, to enable a State to restrict the provider from whom a Medicaid beneficiary can obtain services (other than in emergency cir-

cumstances) to providers who comply with reimbursement, quality, and utilization standards under the State plan.

The committee is informed that three States (California, Illinois, and Washington) are currently operating under this 1915(b)(4) waiver authority to contract with hospitals on a selective basis. The committee bill would require that, in the case of 1915(b)(4) waivers, the timely payment requirements currently applicable to health care practitioners also apply to those providers, including hospitals, that are subject to selective contracting or other restrictions. This requirement would be effective on the first calendar quarter beginning more than 30 days after enactment, and would apply to existing 1915(b)(4) waivers as well as to future waivers.

(j) *Home and Community-Based Services Waivers*

Under current law, the Secretary is authorized to grant waivers to enable States to offer Medicaid coverage for home and community-based services to individuals who, but for such services, would require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF/MR).

(1) *Clarifying Definition of Room and Board.* Under current law, home or community-based services for which payment is authorized by either section 1915(c) or 1915(d) of the Social Security Act do not include room and board. The committee bill would clarify that room and board does not include the portion of costs for rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of the caregiver, would require admission to a hospital, nursing facility, or ICF/MR. This clarification would be effective for services provided on or after enactment.

(2) *Treatment of Persons with Mental Retardation or a Related Condition in a Decertified Facility.* Under current law, the Secretary may only grant a 1915(c) waiver if the State demonstrates that the average per capita Medicaid expenditure for individuals participating in the waiver in a fiscal year does not exceed 100 percent of the average per capita expenditure the State estimates would have been made for these individuals during that year in the absence of the waiver. The committee bill would provide that, in the case of waivers that apply to individuals with mental retardation or a related condition who reside in ICF's/MR terminated from participation in Medicaid, States may determine the average per capita expenditures that would have been made for these individuals as though the facility continued to participate in the Medicaid program. The intent of the committee is to facilitate State efforts to provide home and community-based services to individuals with mental retardation or a related condition who are displaced from an ICF/MR.

(3) *Scope of Respite Care.* Under current law, respite care is one of the home or community-based services that a State may offer through a 1915(c) waiver. The committee bill would clarify that the Secretary may not restrict the number of hours or days of respite care in any period that a State may provide under a waiver, except insofar as the State would violate the waiver authority's overall budget neutrality requirements. In the view of the committee, States should have complete discretion to define the scope of the respite care they choose to offer under a 1915(c) waiver, so long as

they comply with the general waiver limits relating to average per capita expenditures for all home or community-based services.

(4) *Permitting Adjustment in Estimates to Take Into Account Preadmission Screening Requirement.* Under current law, States are required to screen, prior to admission to nursing facilities participating in Medicaid, all individuals with mental retardation or a related condition. The State must determine whether the individual requires the level of services provided by the nursing facility or by an ICF/MR, and whether the individual requires active treatment. If the individual is determined not to require the level of services provided by a nursing facility, the facility is prohibited from admitting the individual. These preadmission screening requirements took effect on January 1, 1989. Under the committee bill, the Secretary would be directed to allow States with 1915(c) waivers for individuals with mental retardation or a related condition to adjust their estimates of average per capita expenditures to take into account increases in expenditures for, or utilization of, ICF's/MR resulting from the implementation of the preadmission screening requirements.

(k) *Spousal Impoverishment*

The Medicare Catastrophic Coverage Act (Public Law 100–360) established minimum requirements for the income and resources a spouse remaining in the community is allowed to keep when her spouse resides in a nursing facility at Medicaid expense. This requirement is effective for individuals institutionalized on or after September 30, 1989.

(1) *Equal Treatment of Transfers by Community Spouse Before Institutionalization.* Under current law, States are required to delay Medicaid eligibility in the case of institutionalized individuals who dispose of resources for less than fair market value during the 30-month period prior to application for benefits. Certain transfers are protected, including transfers by the institutionalized individual to a community spouse, but only so long as the community spouse does not dispose of the resources to a person other than the spouse for less than fair market value. The committee bill would clarify that, for purposes of the prohibitions on transfers of assets, transfers by a spouse of an institutionalized individual would be subject to the same treatment as transfers by the institutionalized individual. For example, if, prior to the institutionalization of her spouse, and within 30 months of the institutionalized spouse's application for Medicaid, a spouse were to withdraw savings from a joint account, place them in her own account, and then give them to a child who is not a minor or disabled, the institutionalized spouse would be subject to a delay in eligibility for Medicaid coverage.

(2) *Clarifying Application to "Section 209(b)" States.* The committee bill would further clarify that the rules and procedures relating to income and resources set forth in section 1924 of the Social Security Act apply in each and every State participating in Medicaid, including "209(b)" States. (These are States that apply more restrictive standards to aged, blind, and disabled SSI recipients for purposes of determining Medicaid eligibility). The committee stresses that "209(b)" States may not comply with the requirements of section 1924 by applying their own resource or income standards or methodologies to institutionalized spouses or community spouses.

(3) *One-Time Computation of Spousal Share.* Under current law, the total value of the resources in which either spouse has an ownership interest is computed as of the beginning of a continuous period of institutionalization of the institutionalized spouse. The committee bill would clarify that this computation is to occur only once, at the beginning of the first continuous period of institutionalization beginning on or after September 30, 1989.

(l) *State Utilization Review Systems.* Under current law, States have the option of implementing various programs to reduce unnecessary utilization of services by Medicaid beneficiaries, including second surgical opinion programs (voluntary or mandatory), inpatient hospital preadmission review, ambulatory surgery, preadmission testing, and same-day surgery programs. The Secretary is prohibited from promulgating regulations to require States to operate mandatory second surgical opinion or inpatient hospital preadmission review programs until 180 days after the submission to the Congress of a report mandated by section 9432(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509).

On June 22, 1989, the Secretary submitted to the Congress a report entitled "High Volume and High Payment Procedures in the Medicaid Population." (85 Cong. Rec. H3082). The committee has reviewed this report and commends the Secretary for its analytical rigor and intellectual honesty. The report will be a useful resource for any State considering adoption of second surgical opinion or preadmission review programs. In the committee's judgment, however, the report does not present persuasive evidence for compelling all State Medicaid programs to operate mandatory second surgical opinion or inpatient hospital preadmission review programs. The report, as it acknowledges, does not contain information from a representative sample of States. Moreover, it does not provide a basis for concluding that Medicaid utilization of surgical procedures is so excessive throughout the country as to warrant the mandatory imposition of such programs in every State. The committee bill would therefore prohibit the Secretary from publishing final or interim final regulations requiring States to operate second surgical opinion programs or inpatient hospital preadmission review programs.

At a hearing held by the Subcommittee on Health and the Environment on June 8, 1989, the HCFA representative provided a statement for the record indicating that HCFA intends to implement a regulatory initiative "to require States to implement effective ambulatory surgery, preadmission testing and same day surgery programs." Under current law, all of these programs are optional. The committee is not persuaded by the evidence available to it that utilization of surgical procedures by Medicaid beneficiaries is excessive nationwide. The committee is also concerned that requiring States which have chosen not to implement such programs to do so may result in the delay or reduction of beneficiary access to needed services. The committee bill would therefore prohibit the Secretary from publishing any final or interim final regulations requiring States to implement programs for ambulatory surgery, preadmission testing, or same-day surgery until 180 days after the submission of a report to the Congress. The report, which would be due January 1, 1992, must contain, for each State in a representa-

tive sample of States, (1) an analysis of the procedures for which such ambulatory surgery, preadmission testing, or same-day surgery programs are appropriate for patients covered under Medicaid, and (2) a description of the effects of such programs on the access of Medicaid beneficiaries to necessary care, quality of care, and costs of care.

(m) *Health Insuring Organizations*

(1) *Treatment of Certain County-Operated Health Insuring Organizations.* Under current law, Federal Medicaid matching payments are not available for services provided on a prepaid capitation or other risk basis by any entity, including a health insuring organization (HIO), unless certain requirements are met. These include a requirement that no more than 75 percent of the enrollees be eligible for Medicare or Medicaid, and a requirement that Medicaid beneficiaries be able to disenroll without cause upon 1 months' notice. Certain HIO's, primarily those that were operational prior to January 1, 1986, are exempt from these requirements, which are intended to assure the quality and accessibility of care in entities participating in Medicaid on a risk basis.

Among the exempt HIO's are three pilot programs operated by the State of California to test the effectiveness of capitulated health systems organized by counties in improving access to quality care for Medicaid beneficiaries. These systems are operated by public entities created by, and responsible to, county boards of supervisors. Financially at risk, these systems organize services for all Medicaid enrollees through contracts with hospitals, physicians, and other providers. The first pilot program, the Monterey County Organized Health System, was unable to control costs and utilization, suffered financial losses, and was terminated. The committee is informed that the other two pilot programs, operating in San Mateo and Santa Barbara counties, are operating without serious problems.

The committee bill would exempt up to three additional county-based HIO's in California from the requirements applicable to risk-based entities under current law. The committee bill does not specify the counties in which these HIO's would operate; they would be designated by the Governor and approved by the State Legislature. However, total enrollment in these three HIO's could not at any time exceed 10 percent of the Medicaid beneficiaries in the State (excluding qualified Medicare beneficiaries). Each of these HIO's must (1) be operated directly by a public entity established by a county under a State enabling statute; (2) enroll all Medicaid beneficiaries residing in the county, not only AFDC recipients; (3) meet the applicable requirements of the Knox-Keene Act and the Waxman-Duffy Act; (4) assure beneficiaries a reasonable choice of providers, including providers that have historically served Medicaid beneficiaries; (5) not impose any restriction which substantially impairs access to covered services of adequate quality where medically necessary; and (6) provides for a payment adjustment for disproportionate share hospitals as required by section 1923 of the Social Security Act.

(2) *Extension of Waiver.* Under current law, the Secretary has waived the application of the 75 percent limit on Medicaid or Medicare enrollees with respect to the Tennessee Primary Care Net-

work, Inc., a prepaid health plan licensed and operating as an HMO under Tennessee law, that has been receiving payment under a prepaid Medicaid contract since May, 1984. The committee is informed that, as of July, 1989, the Network's private enrollees exceed 15 percent of its total enrollees, and that the Network is aggressively seeking additional commercial enrollees. To give the Network additional time to increase its private enrollment, the committee bill would direct the Secretary to continue to waive, on the same terms and conditions, the application of the 75 percent limit through June 30, 1992.

(n) *Day Habilitation and Related Services.* Under current law, States may include among the services covered under their Medicaid programs (1) clinic services and (2) other diagnostic, screening, preventive, and rehabilitative services. Some States have elected, under one or the other of these optional service categories, to pay for day habilitation services to individuals with mental retardation or a related condition, including those who are not residents of ICF's/MR and are not participating in a 1915(c) home and community-based services waiver. The committee understands that 15 States have been providing such services (Arkansas, Idaho, Maine, Massachusetts, Michigan, Minnesota, Missouri, New Hampshire, New Jersey, New York, Rhode Island, Utah, Vermont, Virginia, and Washington) under State Medicaid plans approved by the Secretary.

It has come to the committee's attention that HCFA is threatening to rescind or revoke previously approved State plan provisions for coverage of day habilitation services to individuals with mental retardation or a related condition who do not reside in ICF's/MR. In the view of the committee, HCFA should be encouraging States to offer community-based services to this vulnerable population, not restricting their efforts to do so. Accordingly, the committee bill would prohibit the Secretary from withholding, suspending, disallowing, or denying Federal Medicaid matching funds for day habilitation and related services under a State plan provision approved on or before June 30, 1989. The committee specifically intends that this prohibition apply with respect to such States as Arkansas and Maine, who were providing day habilitation services under an approved State plan but who were notified by HCFA prior to June 30, 1989, that their State plan approvals were being rescinded. The committee bill would further prohibit the Secretary from withdrawing Federal approval of any State plan provision under which day habilitation services have been or are being offered. Thus, HCFA would be required to reinstate the approvals of the plan provisions of such States as Arkansas and Maine that HCFA has attempted to withdraw.

Under the committee bill, these prohibitions would apply until the Secretary promulgates a regulation specifying the types of services that a State may cover under the optional service categories of clinic or other rehabilitative services. The committee bill would not require the Secretary to issue such a regulation. However, the Secretary would be prohibited from withholding, suspending, disallowing, or denying Federal Medicaid matching funds with respect to day habilitation or related services offered by a State under a State plan provision approved on or before June 30, 1989, unless and

until the Secretary issues a final regulation and determines that a State plan does not comply with the regulation. The regulation, if any, would have to be promulgated after a notice of proposed rulemaking and at least 60 days for public comment, and would have to specify the types of day habilitation and related services that a State may cover under the optional service categories and any requirements respecting such coverage. If the Secretary finds that a State plan does not comply with the final regulation, the committee bill would require the Secretary to notify the State of the determination and its basis. The committee bill would preclude the Secretary from withholding, suspending, disallowing, or denying any Federal Medicaid matching funds pursuant to such a determination for day habilitation services provided before the first day of the first calendar quarter beginning after the date of the notice to the State.

The committee notes that, under section 4221 of the committee bill, States would have the option to offer community habilitation and supportive services to individuals with mental retardation or a related condition. One element of this new optional service benefit is day habilitation and related services. The committee emphasizes that day habilitation and related services offered by States under the optional service categories of clinic services or other rehabilitative services are not subject to the same requirements that would apply to day habilitation and related services offered as an element of community habilitation and supportive services. For example, under section 4221, day habilitation and related services could only be offered as a supplement to the core benefits of case management, respite care, and personal attendant care. This core benefits requirement would not apply to day habilitation services offered under the optional service categories of clinic or other rehabilitative services.

Other Matters (Not Addressed in the Committee Bill)

The committee wishes to clarify with respect to payments by States under Medicaid that providers may use Medicaid receivables as collateral for loans, or may sell such receivables, so long as payment by States under Medicaid for services rendered by the provider is always made directly to the provider.

Subtitle D—Maternal and Child Health Program

Established in 1981 at Title V of the Social Security Act, the Maternal and Child Health (MCH) Block Grant (also known as "Title V") represents a consolidation of seven previous formula and categorical programs designed to serve mothers, pregnant women, infants, and children. Under the MCH Block Grant, Federal funds are available to the States for the provision or the purchase of a broad range of maternal and child health services that will help States in (i) reducing infant mortality; (ii) increasing the availability of prenatal, delivery, and postpartum care to low-income women; (iii) reducing the incidence of preventable and handicapping conditions among low-income children; (iv) increasing the number of children immunized against disease and receiving health assessments; and (v) providing medically necessary services

to children with handicaps or "children with special health care needs."

Eligibility criteria under the MCH Block Grant are set by the States themselves. States may elect to charge for services provided. No charges may be imposed, however, for services provided to mothers and children whose incomes fall below the Federal poverty level.

Funds are allocated among the States based on their proportional share of 1981 outlays for the various programs consolidated into the MCH Block Grant. In order to receive their allocation, however, States must meet a matching requirement: for every $4 in Federal funds a State receives under Title V, the State must spend $3 of its own moneys on maternal and child health services.

The Title V law provides that between 10 and 15 percent of the amounts appropriated in each fiscal year are to be withheld from the States and administered by the Secretary. Known as the Federal "set-aside", these funds support a variety of designated activities. An additional amount of funds has been withheld through fiscal year 1989 to establish and operate projects for the screening of sickle-cell anemia and other genetic disorders.

The authorization level for the MCH Block Grant in fiscal year 1990 and subsequent years is $561 million. Appropriations for Title V for fiscal year 1989 are $554.3 million.

Sec. 4301—Increase in Authorization of Appropriations

(a) *Purpose of Program.* Current Title V law sets out a number of purposes for which the States and the Secretary are authorized to expend appropriated MCH Block Grant funds. For the States, such purposes include (i) providing and assuring access to quality maternal and child health services for mothers and children with low incomes or with limited availability of health services; (ii) reducing infant mortality, the incidence of preventable and handicapping conditions, and the need for inpatient and long-term care services among children, and increasing the number of children immunized against preventable diseases and the number of low-income children receiving health assessments and follow-up diagnostic and treatment services; (iii) providing rehabilitation services for blind and disabled children under the age of 16 receiving benefits under Title XVI of the Social Security Act; and (iv) providing various services for "children with special health care needs." For the Secretary, such purposes include providing for (i) special projects of regional and national significance ("SPRANS" Projects); (ii) research and training projects relating to maternal and child health; (iii) genetic disease testing, counseling and information projects; (iv) grants relating to hemophilia; and (v) newborn genetic screening projects.

The Title V statute does not, however, specify any national maternal and child health goals or objectives that should be attained, in part, through funds made available under the MCH Block Grant. Over the years, this lack of program direction, coupled with the law's De minimis reporting requirements, has made it difficult for Congress to determine the MCH Block Grant's effectiveness in meeting the Nation's maternal and child health needs.

The committee believes that the establishment of national goals and objectives for the MCH Block Grant program is in the best interests of both Title V and the individuals it is authorized to serve. Thus, the committee bill amends section 501(a) of the Title V statute to establish—through reference to the Department's soon-to-be-published *Year 2000 National Health Objectives* ("Year 2000 Objectives")—health status goals and national health objectives for the MCH Block Grant.

The "Year 2000 Objectives" report represents a revision and update of the Department's 1980 release, *Promoting Health/Preventing Disease: Objectives for the Nation.* That volume set out specific and measurable objectives for a number of priority areas that have been identified by the Department as the cornerstones for the continued improvement in the health of the American people. Among those priority areas are (i) maternal and infant health; and (ii) immunization and control of infectious diseases. The new report will retain these two categories as priority areas and will establish within each, a number of objectives that should be met by public health authorities within the next decade, if the national goal of enhancing the health status of all mothers and children is ever to be reached.

It is primarily to these two priority areas (and to the objectives cited within each) that the committee is referring in amending section 501(a) to specify the "applicable" health status goals and national health objectives established by the "Year 2000 Objectives" report. In particular, within the area of maternal and infant health, the committee intends that the MCH Block Grant be designed to help meet, at a minimum, the "Year 2000 Objectives" established for (i) rates of infant mortality; (ii) rates of low-birth weight babies; (iii) rates of maternal mortality; (iv) rates of neonatal death; (v) rates of perinatal death; and (vi) the proportion of women who deliver who do not receive prenatal care during their first trimester of pregnancy. Within the area of immunization and the control of infectious diseases, the committee intends that the MCH Block Grant be designed to help meet, at a minimum, the "Year 2000 Objectives" established for immunization levels for children under 2 years of age. The committee further intends that the objectives specified within each priority area form the basis for individual programs and projects funded by both the Secretary and by the States.

The committee notes that there are other applicable "Year 2000 Objectives" that the committee expects to be incorporated into the design and operation of the MCH Block Grant. Among these are the objectives relating to (i) the health status of adolescents; (ii) health education and access to preventive health services; and (iii) surveillance data systems. Again, the committee intends that the objectives specified within each of these priority areas be applied to programs and projects funded by either the Secretary or by the individual States.

(b) *Purposes for Which States are Authorized to Expend Funds.* As noted above, under current law, Title V targets specified individuals and services for which States are authorized to expend appropriated MCH Block Grant funds. The committee bill makes no changes in the classes or groups of individuals that may be eligible

for services under an individual State Title V program. It does, however, include some clarifications with respect to the services that a State may provide to such individuals.

With regard to blind and disabled children under the age of 16 who are receiving benefits under Title XVI of the Social Security Act, the committee bill makes clear that State Title V programs can provide rehabilitation services only to the extent that such services are not covered under a State's Medicaid program. Because MCH Block Grant dollars are in such short supply, the committee believes it is inappropriate for Title V to pay for rehabilitation services for this population if such services are already provided under a State's Medicaid plan. If, however, a State's Medicaid plan does not provide coverage for these services, the Title V program may be the most appropriate source for assistance. Under the committee's bill, States are authorized to provide such assistance only in these limited circumstances.

With regard to "children with special health care needs", the committee bill makes clear that State Title V programs can provide case management or "care coordination" services to assist this population and their families in obtaining the various types of services such children may require. While the term "care coordination" services is a new one for the Title V statute, the committee bill defines it to include those services now specified by the Secretary under section 502(c)(D)(iii) of the current law.

(c) *Purposes for Which the Secretary is Authorized to Expend Funds.* Again, as noted above, current Title V law specifies a number of programs and projects for which the Secretary is authorized to expend appropriated MCH Block Grant funds directly. Such programs and projects are funded through two different Federal "set-asides" which are made up of moneys that are obligated directly by the Secretary.

The first set-aside, for special projects of regional and national significance ("SPRANS"), was established in 1981 and is designed to fund "SPRANS" projects and other programs relating to maternal and child health training and research, genetic diseases, and hemophilia. Under current law, the Secretary is required to retain between 10 and 15 percent of appropriated MCH Block Grant funds to support these programs.

The second set-aside was established in 1986 and is designed to fund projects for the screening of newborns with sickle-cell anemia and other genetic disorders. Under current law, the Secretary is required to retain 9 percent of appropriated MCH Block Grant funds over and above a certain level to support these projects. Current law also provides that the authority for this set-aside expires at the end of fiscal year 1989.

The committee bill retains the current structure of the Title V statute by providing for two different Federal set-asides. It amends current law, however, by making modifications in the statute's requirements relating both to the amount of appropriated funds that must be retained by the Secretary for each set-aside, and to the purposes for which the set-aside moneys are to be used.

(1) *"SPRANS" Set-Aside.* Under the committee bill, the Secretary is required to retain a full 15 percent of the amounts appropriated to the MCH Block Grant for programs and projects of the type cur-

rently funded under the "SPRANS" set-aside (see section 4302, below). Such programs and projects include those for comprehensive hemophilia diagnostic and treatment centers which have received Federal set-aside funds over the last several years.

In addition, these programs and projects include those for early intervention training and services development. The committee has specified these training and service development programs and projects in response to the critical shortage of allied health professionals needed to provide care to the thousands of infants and toddlers with disabilities who will soon become eligible to receive health-related services under the 1986 Education of the Handicapped Act (Public Law 99–457). The committee stresses, however, that in including this provision in the committee bill, it is authorizing the use of Title V funds for the *sole* purpose of developing service capacity (through personnel training and services development projects) to address the health-related needs of disabled infants and toddlers to be served under Public Law 99–457; it is *not* authorizing the use of Title V dollars for payment for any actual services that are to be provided under Public Law 99–457. Such services are to be funded with moneys made available under that law.

(2) *Infant Mortality, Newborn Genetic Screening, and Rural Services Set-Aside.* Under the committee bill, the Secretary is required to retain an additional 12.75 percent of the amounts appropriated to the MCH Block Grant to support infant mortality programs, newborn genetic screening projects, and service programs for mothers and children living in rural areas (see section 4302, below).

The committee bill specifies four categories of infant mortality initiatives that are to be supported through this set-aside: (i) maternal and infant health home visiting programs; (ii) integrated maternal and child health service delivery systems; (iii) maternal and child health centers operated under the direction of not-for-profit hospitals; and (iv) projects designed to increase the participation of obstetricians and pediatricians under both the Title V and Title XIX (Medicaid) Programs. Two-thirds of the amounts appropriated under this set-aside are to be used to fund these initiatives (see section 4302, below). As the bill makes clear, each of these programs and projects must be funded by the Secretary, although the number of such programs and projects within each category remains within the Secretary's discretion. Within each category, however, the Secretary must give preference to qualified applicants able to demonstrate that their initiatives will be carried out in areas with a high infant mortality rate (relative to the average infant mortality rate in the United States or in the State in which the area is located).

The committee's emphasis on the first category of infant mortality initiatives—maternal and infant health home visiting programs—comes in response to the findings and recommendations of the National Commission to Prevent Infant Mortality. Created by Congress in 1986, the initial focus of the Commission was to review existing programs and policies directed at the health of women of child-bearing age and their infants. Its year-long study, *Death Before Life: The Tragedy of Infant Mortality,* was released in 1988. In it, the Commission called for a number of programmatic improvements, including the development and expansion of home

visitors projects for pregnant women and new mothers—particularly for those in high-risk populations. In its more recent report, *Home Visiting: Opening Doors for America's Pregnant Women and Children,* published in July 1989, the National Commission again found that "home visiting is an effective, cost-saving, community-oriented strategy that works . . . to promote and protect the health of pregnant women and children", and reaffirmed its view that home visiting programs should be supported and expanded. The committee bill, in providing for maternal and infant health home visiting programs, is designed to implement the Commission's recommendation.

The purpose of these programs, as envisioned by the committee, is to educate and work with pregnant women and mothers of infants to promote healthy outcomes. To achieve this goal, the committee bill specifies that home visiting programs provide case management services, health education services, and related social support services to pregnant women or to families with an infant up to age one, in the home. Under the committee bill, such services must be designed to assure access to quality prenatal, delivery, and postpartum care for pregnant women, and to assure access to quality preventive and primary care services, including immunizations and well-baby care, for infants. In addition, the committee believes that these services should be structured so as to encourage healthy behaviors such as reducing or quitting smoking and improving dietary habits, and to help lower the incidence of accidents, abuse, and neglect. As specified in the bill, each of these services is to be provided by an appropriate health professional or by a qualified non-professional (such as a trained community worker) who is acting under the supervision of a health professional.

As discussed in section 4203, above (optional Medicaid coverage of prenatal and postpartum home visitation services), the committee bill, in addition to expanding Medicaid eligibility for pregnant women, infants and children, also establishes a new optional Medicaid benefit for prenatal home visitation services for high-risk pregnant women (as prescribed by a physician) and/or post-partum home visitation services for high-risk infants under age one (as prescribed by a physician). Thus, under the committee's bill, a State could have two home visiting programs in effect at the same time (if the State elected to exercise the new Medicaid option, and if it applied for, and were awarded, during the same period, a Title V Federal set-aside grant for a home visiting program).

The committee stresses that it has no objections to such an arrangement. It would emphasize, however, that under such circumstances, the committee does not intend—nor does current law allow—for the State's Title V Federal set-aside funds to be used to pay for services that are covered under the State's Medicaid home visitation benefit. For example, if a State were to elect to pick up the Medicaid home visitation option and if, at the same time, it were awarded a Title V Federal set-aside grant for a home visitors program, the State's Title V Federal set-aside funds could not be used to pay for home visiting services provided to a pregnant woman (or to any other individual) eligible for Medicaid. Nor could they be used to supplement Medicaid *payments* for such services—or any other Medicaid-covered services—provided to an individual

eligible for Medicaid. Such funds could be used, however, to support additional *services* (that is, services not covered under a State Medicaid plan) provided to Medicaid-eligible individuals.

The committee notes that, in specifying these payment responsibilities, it is merely following current law which requires that Medicaid act as the first payor for services covered under a State's Medicaid plan.

In addition to its recommendation concerning the establishment of home visitors programs, the National Commission on Infant Mortality has called for the development and expansion of integrated maternal and child health service delivery systems. Such systems are designed to provide access—in one location—to a number of services needed by low-income or high-risk pregnant women and their young children. These services include those provided under both the Title V and Medicaid Programs; the Supplemental Food Program for Women, Infants, and Children ("WIC"); the Head Start Program; and other appropriate health and health-related programs. In authorizing funds for this second category of infant mortality programs, the committee intends to implement this recommendation of the National Commission.

In carrying out the Commission's recommendation, the committee intends that systems funded under this Title V set-aside not only provide access to the services specified above, but also coordinate the application processes for, and the actual delivery of, these services so as to cut down on administrative costs and client frustration and confusion. To further this goal, the committee bill requires that these integrated maternal and child health service delivery systems use the model application form that is to be developed by the Secretary under section 4306 once it becomes available in 1990. As discussed below, this form is to be used in applying, simultaneously, for assistance for a pregnant woman or a child under the age of six under a variety of specified maternal and child assistance programs. Until such form becomes available, however, the committee intends that systems funded under this set-aside make every effort both to coordinate and to expedite the application process for services that are to be provided.

Hospital-based maternal and child health centers which provide prenatal, delivery, and postpartum care for pregnant women and preventive and primary care services for infants up to age one, are the third category of infant mortality projects to be funded under this set-aside. Applicants must be not-for-profit hospitals and should be located in the geographic area of the individuals whom they intend to serve.

Applicants must also agree to provide all of the services specified in the bill in order to be designated as a maternal and child health center. The committee emphasizes this requirement to underscore its view that prenatal, delivery, and postpartum services are most effective when delivered as a continuum of care and not in an episodic fashion. Thus, the committee intends for centers to provide each of the services specified in the bill to each pregnant woman and each infant who participates in a center's maternal and infant health program.

In addition to these requirements, applicants must agree to use non-Federal funds to match each Federal dollar that is provided under this set-aside.

The purpose of the fourth category of infant mortality initiatives that is to be supported through this set-aside is to increase the participation of obstetricians and pediatricians under both Title V and Medicaid. Such initiatives are to test innovative approaches to removing identified barriers to program participation by obstetricians and pediatricians so as to provide greater access to prenatal, delivery, and postpartum care for pregnant women, and to preventive and primary care for infants and young children. The committee intends that such innovations include expediting reimbursement and using different payment mechanisms such as global fees for maternity and pediatric services (with guaranteed periodic payments); assisting in securing, or paying for medical malpractice or otherwise sharing in the risk of liability for medical malpractice; decreasing unnecessary administrative burdens in submitting claims or securing authorization for treatment; and covering medical services such as prenatal vitamins or other nutritional supplements. The committee does not intend, however, that such innovations include the authority to limit eligibility under either a State's Title V or Medicaid program or to reduce any services that these programs provide. Nor does the committee intend that such innovations include the authority to waive any Medicaid requirements, including the requirements relating to freedom to choice.

Under the committee bill, the remaining one-third of the amounts appropriated under this set-aside are to be used to support projects to screen newborns for sickle cell anemia and other genetic disorders together with follow-up services, and for maternal and child health projects to serve rural populations (see section 4302, below). At least 25 percent of the amounts made available are to be retained by the Secretary to carry out newborn genetic screening programs and at least 25 percent of the amounts appropriated are to be retained by the Secretary to carry out maternal and child health projects in rural areas. The remaining 50 percent of the funds may be allocated to either type of project at the discretion of the Secretary.

With respect to newborn genetic screening projects, the committee intends that the Secretary support the type of program that was established under the 1986 amendments to the MCH Block Grant (Public Law 99–509). The committee notes, however, that the bill includes the provision of follow-up services as part of the screening process and emphasizes the requirement that such services be provided by all projects funded under this set-aside.

With respect to maternal and infant health projects in rural areas, the committee intends that the Secretary fund initiatives to help combat infant mortality and to otherwise improve the health of pregnant women, mothers, and children. The committee has given the Secretary broad discretion in determining how such programs are to be structured and to be carried out. Nonetheless, the committee intends that the Secretary design these projects consistent with the goals and objectives of the MCH Block Grant, including those specified in section 4301(a), above.

(d) *Authorization of Appropriations.* Under current law, the authorization level for the MCH Block Grant Program is $561 million. The committee bill increases this amount to $661 million, effective fiscal year 1990 and each fiscal year thereafter.

Sec. 4302—Allotments to States and Federal Set-Asides

Under current law, funds are allocated under the MCH Block Grant in accordance with the following formula. Of the amounts appropriated in each fiscal year, between 10 and 15 percent of the total are retained directly by the Secretary to support various "SPRANS" projects. In those years in which appropriations for Title V exceed $478 million, an additional 9 percent of the remaining appropriations are also retained directly by the Secretary to fund newborn genetic screening projects. In such years, two-thirds of the balance is allocated directly to the Secretary to fund additional "SPRANS" projects and to the States for various maternal and child health services. The remaining one-third is also allocated directly to the Secretary and to the States. However, these funds must be used by both the Secretary and the States for primary care services for children, and for community-based service networks and case management services for "children with special health care needs." The authority for the Federal set-aside for newborn genetic screening programs expires at the end of fiscal year 1989. The authority for the other parts of this formula have no fixed expiration date.

The committee bill makes a number of changes in this formula.

With respect to Federal set-asides, the committee bill requires that a full 15 percent of the amounts appropriated in each fiscal year be retained directly by the Secretary to support "SPRANS" projects. An additional 12.75 percent of such amounts is also to be retained directly by the Secretary to fund programs and projects authorized under the infant mortality, newborn genetic screening, and rural services set-aside. As noted previously (see section 4301(c)(2), above), two-thirds of the funds allocated to this set-aside are to be used to support infant mortality initiatives; the remaining one-third must be targeted for newborn genetic screening projects and maternal and child health programs in rural areas.

As under the current law, the moneys that remain after allocations are made for the two Federal set-asides are to be distributed among the States on the basis of their proportional share of 1981 outlays for the various categorical programs consolidated into the MCH Block Grant. Under the committee bill, this allotment formula has been updated and abbreviated for the sole purpose of making its calculations simpler and easier. No changes in the actual computation of the formula are intended by the committee and none should be implemented by the Secretary on the basis of this section of the legislation.

With respect to State MCH Block Grant dollars, the committee bill requires that, effective with appropriations made available as of fiscal year 1991, States must use at least 30 percent of their allotted funds for services for pregnant women, mothers, and infants up to age one; at least 30 percent for services for children; and at least 30 percent for services for "children with special health care

needs". The remaining 10 percent of allotted moneys are to be allocated at each State's discretion (see section 4303, below).

Sec. 4303—Use of Allotment Funds and Application for Block Grant Funds

(a) *State Applications.* Under current law, in order for States to be entitled to receive their allotments of MCH Block Grant funds, they must submit to the Secretary both a report that describes their intended use of the payments, and a "statement of assurances" that is designed to certify the States' compliance with a number of specified conditions. However, because States have varied in their commitment to meet these requirements, these documents, in general, have proven to be inadequate for the Department to make assessments and determinations about individual State Title V programs.

In order for the Secretary to evaluate more accurately the various State Title V programs, the committee bill amends section 505 of the current law to require, effective with fiscal year 1991, that all States submit to the Secretary a formal application, prepared in consultation with the State maternal and child health agency, for Secretarial review. At that time, States will no longer be required to file reports of intended expenditures or statements of assurances. Instead, they will be required to submit only a single application, in a standardized form, to be specified by the Secretary. The committee intends that such application form be developed by the Department's Bureau of Maternal and Child Health and that it be prepared in consultation with the various organizations, including the State Title V agency directors, that are concerned about, and directly involved with, the delivery of maternal and child health services.

With respect to the application itself, the committee's legislation requires that States use at least 30 percent of their Title V allotments for preventive and primary care services for pregnant women, mothers, and infants up to age one; 30 percent for preventive and primary care services for children; and at least 30 percent for services for "children with special health care needs" (the so-called "30-30-30" formula). The remaining 10 percent of funds is to be dedicated to any one of these three groups at the State's discretion. The committee bill does not require States to provide any specific types of services to these classes. Under current law, however, States must specify what services they do intend to provide. The committee bill makes no changes in that mandate.

The committee's allocation formula is designed to ensure that each class of individuals that is targeted under the goals and objectives of the Title V statute, and that is eligible to receive services, will benefit from Title V funds. In addition, the formula is designed to ensure that States are able to continue to exercise their discretion in determining what types of services are to be provided to each class of individuals.

The formula is further designed to ensure that States are able to address extraordinary unmet maternal and child health needs in certain unusual circumstances. Thus, the committee bill provides for a waiver of the State "30-30-30" allocation formula if the Secretary determines that each of following conditions has been met: (i)

on the basis of its most recent annual report to the Secretary, the State has demonstrated, in its application, an extraordinary unmet need for services for one of the designated classes of individuals; (ii) the granting of a waiver is justified and will assist in carrying out the goals and objectives of the MCH Block Grant; and (iii) the State provides assurances that each class of individuals will receive some services and specifies the percentages that are to be substituted for those mandated under the "30-30-30" formula. Waivers may be granted only by the Secretary and only for the fiscal year for which an application containing a request for a waiver has been submitted.

The committee notes that it is unaware of any State that would be adversely affected by the implementation of the bill's "30-30-30" State allocation formula. Thus, it expects both the number of requests for waivers and the number of waivers granted by the Secretary, to be few.

The committee bill also provides that applications specify the State's Title V goals and objectives in view of "Year 2000 Objectives" as discussed in section 4301(a), above. Since the committee bill establishes the attainment of these objectives as the general purpose of the MCH Block Grant Program, the committee believes it is appropriate to require States to fix their own individual maternal and child health goals in light of these national standards and to specify those individual goals in their applications to the Secretary.

In this regard, the committee notes that no State is to be penalized through the loss of Title V funds for not attaining either the "Year 2000 Objectives" or its own individual maternal and child health goals. The purpose of establishing national maternal and child health objectives, and of requiring States to develop and specify their own maternal and child health goals (in relation to the national objectives), is to implement a process by which the maternal and child health status of the Nation can be measured. Thus, the purpose of these requirements is not to punish States if, in a given year, they are unable to reach the goals they have set for themselves. Nor is it their purpose to hurt States if, in a given year, they do not achieve the "Year 2000 Objectives".

The committee bill further provides that applications specify the information States will collect in order to prepare the reports that are to be submitted to the Secretary on an annual basis (see section 4304, below). The committee intends that such information include not only a description of the actual data that is to be collected, but a description of the methodology by which such data is to be obtained.

In addition to these requirements, the committee bill provides for a number of application standards that relate to the Medicaid program. Such requirements are designed to assure that (as discussed in section 4301(c)(2), above), limited Title V funds are not used to purchase services for women and children eligible for Medicaid, unless those services are not covered under the State's Medicaid program.

To assure that Title V is, indeed, the second payor, the committee bill requires that each Title V provider or practitioner enter into a participation agreement to deliver services to individuals en-

titled to care under a State's Medicaid plan. Such providers must be qualified not only to deliver services under the Title V program, but under this provision of the committee bill, they must also be qualified to receive payments under the State Medicaid plan.

The committee bill also requires that Title V agencies provide for services to identify pregnant women and infants who are eligible for services under the State's Medicaid plan and to assist them in applying for Title XIX assistance. Since the committee's bill mandates that MCH Block Grant providers participate in the Medicaid program, the committee believes this additional requirement does not impose a significant burden on State Title V agencies. Indeed, in the committee's view, this requirement—in conjunction with the Medicaid mandate described above—will help ensure that State Title V agencies provide care only to those individuals whom the MCH Block Grant is designed to serve: those mothers and children who are not eligible for services under Medicaid, or whose services are not covered under the State's Medicaid plan (or a private health insurance program).

(b) *Use of State MCH Block Grant Funds.* Under section 504 of the current Title V law, States are authorized to use their MCH Block Grant funds for a number of specified maternal and child health activities. The committee bill amends this section of the law to include among these authorized activities, support for National Health Service Corps personnel. Under this provision, States could, at their option, use Title V funds to pay the salaries and other related expenses for Corps personnel who deliver Title V services.

(c) *Limitation on State MCH Block Grant Funds for Administrative Costs.* Under the current Title V statute, there are no limitations on the amount of allotted funds that States may use for administrative costs. The committee bill places a ceiling on such costs at no more than 10 percent of the amounts allocated to each State under Title V, thus assuring that most Title V dollars will be spent on the delivery of services. The committee notes that such restrictions are consistent with those imposed under other State block grant programs such as the Preventive Health and Health Services Block Grant and the Alcohol and Drug Abuse and Mental Health Services Block Grant, authorized under Title XIX of the Public Health Service Act.

Sec. 4304—Reports

(a) *State Reports.* Under current law, States are required to provide minimal information to the Secretary on the activities that they fund under Title V. Current law also requires virtually no data from the States on the extent to which their Title V programs are making progress in improving the health status of mothers and children. In addition, the statute does not call for standardized report forms or for uniform data collection and reporting requirements.

The committee believes that the establishment of specific, uniform State data collection and reporting requirements for the MCH Block Grant is long overdue and is essential for States to be able to compare their performance and progress under Title V with that of the other States. Thus, the committee bill amends section 506 of the Title V statute to require, effective fiscal year 1991, that State

reports be prepared and submitted for review in such standardized form as specified by the Secretary. In addition, the legislation requires that such reports include a description of the extent to which a State has met the goals and objectives it set forth in its application for funds, and the extent to which a State has met the "Year 2000 Objectives" (see section 4303, above).

The committee bill further requires that such reports contain certain information and data which the committee believes are essential for an effective evaluation of both individual State MCH Block Grant programs and the entire Title V authority. More specifically, States are required, on an annual basis, to report by class of individuals served, on the number of individuals served by the State under Title V; the proportion of such individuals who have health insurance; the types of services provided; and the amounts spent on each type of service. As defined under the bill, such classes of individuals include pregnant women, infants up to age one, children with special health care needs, other children under the age of 22, and other individuals. In addition, the committee bill requires that State reports include information on a range of health status and health care utilization indicators. Such information will provide the Secretary with the data that are necessary to evaluate, measure, and compare individual State Title V programs and to report to Congress—for the first time under the Title V law—on the current health status of the Nation's mothers and children.

(b) *Secretarial Report.* Under current Title V law, the Secretary is required to report to the Congress only on the activities funded under the "SPRANS" Federal set-aside; there is no requirement that he report to the Congress on the programs and projects supported by State MCH Block Grant dollars, or on the outcomes that have been achieved through Title V. Thus, the committee bill requires, effective fiscal year 1991, that the Secretary transmit to the Congress, on an annual basis, a detailed, comprehensive report on the activities, programs, and outcomes of the MCH Block Grant.

More specifically, the committee bill requires that this report include a description of each of the projects funded under the two Federal set-asides (see section 4301(c), above); a summary of the information provided by the States in their annual reports to the Secretary; based upon the data supplied by the States to Secretary, a compilation of various key maternal and child health indicators; information on the number of pregnant women and infants receiving services under either the MCH Block Grant or Medicaid programs; and an assessment of the progress being made to meet the health status goals and national health objectives discussed in section 4301(a), above.

In the committee's view, this report is to serve as the basis for measuring the Nation's advancements in maternal and child health. The committee expects, therefore, that this report will contain each of the items specified in the Title V statute.

Sec. 4305—Federal Assistance in Data Collection Mechanisms

Under section 509 of the current Title V law, the Federal Bureau of Maternal and Child Health has responsibility for providing a range of MCH Block Grant program support activities to the States. Under the committee bill, this section of the law is amend-

ed to expand the Bureau's areas of assistance to include the development of consistent and accurate data collection mechanisms that are necessary for States to be able to provide the required information in their annual reports to the Secretary.

Sec. 4306—Development of Model Application Form for Maternal and Child Assistance Programs

Over the years, Congress has created a number of successful, cost-effective maternal and child assistance programs targeted to pregnant women and children ages zero through six. These include the MCH Block Grant; the Medicaid program; the migrant and community health centers programs; the health care for the homeless grant program; the Supplemental Food Program for Women, Infants, and Children (WIC); and the Head Start Program.

Despite their common cause, these programs are supported through several different authorities and more often than not, have very different requirements. As a result, individuals who are entitled to receive services under more than one of these programs are frequently unaware of their eligibility or are frustrated by bureaucratic redtape in their attempts to obtain care.

As the National Commission to Prevent Infant Mortality suggests in its 1988 report, *Death Before Life: The Tragedy of Infant Mortality,* one of the most effective ways to address this problem is to streamline or refine the application process for these various programs. The committee agrees. Thus, the committee bill requires the Secretary (in consultation with the Secretary of Agriculture) to develop (within 1 year of the enactment of this legislation) a model application form for use in applying, simultaneously, for assistance for pregnant women and children under age six under the maternal and child assistance programs specified above.

The committee intends that this application form be as simple and as easy to understand as possible so as to avoid the costly and complicated application efforts that now consume both program beneficiaries and program agencies. It further intends that the Secretary, in preparing the model application form, consult with the various State agencies that administer these maternal and child assistance programs, as well as other organizations that actually provide maternal and child assistance services.

Once developed, the committee bill also requires that the model application be disseminated to each State agency responsible for administering a maternal and child assistance program. The bill does not require any State agency to adopt the model form. The bill does require, however, that integrated maternal and child health service delivery systems funded under the legislation's Title V infant mortality, newborn genetic screening, and rural services Federal set-aside, use the model application in their programs as soon as it becomes available (see section 4301(c)(2), above).

Sec. 4307—Research on Infant Mortality and Medicaid Services

With the expansion of the Medicaid program to improve access to prenatal care for pregnant women, the need for research on the relationship between the receipt of prenatal care under Medicaid and infant mortality as grown. Under the committee bill, the Sec-

retary is required to support such research by developing a national system for linking birth, infant death, and Medicaid data.

It is the committee's understanding that the structure for implementing such a system has already been developed and put into place by the National Center for Health Statistics (NCHS). Under the NCHS program, information found on birth certificates (such as infant birthweight, mother's receipt of prenatal care, and other risk factors) is linked with information recorded on infant death certificates. The purpose of this section of the committee's bill is to provide for the development of a national system that will allow HCFA Medicaid data to be integrated into the NHCS program.

Sec. 4308—Effective Dates

(a) *In General.* Except for the provisions relating to State applications for Title V funds (section 4303(a)) and to State and Secretarial Title V reports (section 4304), the amendments made under this subtitle of the committee bill are to apply to appropriations for fiscal years beginning with fiscal year 1990.

(b) *Title V Applications and Reports.* The amendments made under this subtitle relating to State applications for Title V funds (section 4303(a)) and to State and secretarial Title V reports (section 4304) are to apply for fiscal years beginning with fiscal year 1991.

Subtitle E—Miscellaneous Health-Related Provisions

Sec. 4401—Congressional Access to Information

Section 301(j) of the Federal Food, Drug and Cosmetic Act prohibits the release of certain information. The committee's bill would amend that section to clarify that the section does not authorize the withholding of information from Congress. As amended, the section would simply restate the authority of the Congress to get information from the executive branch.

Sec. 4402—Vaccine Injury Compensation Technicals

The National Childhood Vaccine Injury Act of 1986 (Public Law 99-660) created a system for compensating children for injuries received from routine pediatric immunizations. The Vaccine Compensation Amendments of 1987 (Public Law 100-203) provided for a source of payment for such compensation and began the functioning of the system.

Since that time the U.S. Claims Court, which was designated as the forum for the resolution of these vaccine injury claims, has received more than a hundred petitions for compensation for injuries associated with vaccines administered before October 1, 1988, the effective date of the program. No claims for compensation for injuries associated with vaccines administered after the effective date have yet been received.

In addition, vaccine prices, which had skyrocketed as much as 2,000 percent before the enactment of the compensation system, have stabilized. Indeed, some manufacturers have demonstrated renewed interest in the U.S. vaccine market.

Several problems have, however, emerged in the system as it has been begun. Some are technical in nature and are easily corrected.

20-456 O - 89 - 7

Others are problems created by unforeseen circumstance, such as the delay in initial receipt of claims. These difficulties, while not technical, are also easily corrected.

But most important are other, more fundamental problems—principally in the nature of the adjudication of petitions—which cannot be remedied by statutory change alone. Correction of these problems will require revision of the vaccine rules of the Claims Court and a re-dedication of all parties to the creation of an expeditious, non-adversarial, and fair system.

The committee proposes statutory amendments to address these difficulties with serious concern about the situation that has arisen since the receipt of the first claims. The Report accompanying the original Act makes clear that the committee intended a quick, flexible, and streamlined system. (H.Rept. No 99–908, 99th Cong., 2nd Sess., Sept. 26, 1986) That Report called for a compensation procedure that administered awards "quickly, easily, and with certainty and generosity." The system was intended to be "fair, simple, and easy to administer" and "to compensate persons with recognized vaccine injuries without requiring the difficult individual determinations of causation of injury." The powers of discovery within the proceeding were given over to the Master, with "neither party ... given power to cross-examine witnesses, file interrogatories, or take depositions" in order "to replace the usual rules of discovery in civil actions in Federal Courts."

The committee has come to understand that rather than establishing such a system, all participants have, to some degree, maintained their traditional adversarial litigation postures. The Claims Court has issued rules for vaccine proceedings that force proceedings to be formal and that virtually foreclose any opportunity for petitioners or respondents to proceed without litigators at their sides. Petitioners have failed to include adequate information in initial petitions and have pursued traditional rights of exclusion of evidence. Respondents have withheld sufficient personnel and administrative support and mounted defenses incompatible with a no-fault system of compensation.

In proposing this legislation, the committee reiterates its intent that the vaccine injury compensation system be informal, flexible, and expeditious, and that all participants proceed accordingly. The re-invention of the adversarial process will serve neither to compensate injured children nor maintain the stability of the immunization programs of the United States.

The committee also reiterates its expectation that the Special Master and the powers given to the Master will allow the proceedings to be direct and straightforward. The Master should be able to require from petitioners and respondents information sufficient to evaluate the petition without resort to complex proceedings.

With such re-dedication to the original goals of the program, the committee anticipates that all participants will benefit. The system will provide compensation, eliminate the need for litigation, and assure the continued availability of and public confidence in immunizations in the United States.

(a) *Reference.* Section 4402(a) establishes that all references are made to the Public Health Service Act.

(b) *Petitions.* Paragraph (1) clarifies that certain information must be included in the original petition to the Claims Court in order to initiate a compensation proceeding. The committee has received reports from the Department of Health and Human Services (DHHS) and the Department of Justice (DOJ) that petitions have been accepted containing little or none of the information needed to review the claim for compensation. The committee has also heard from representatives of petitioners that the granting of the authority to initiate claims of compensation to the respondents would work a hardship on petitioners and could result in delay. The committee acknowledges that the current content required by all of Section 2111(c) could form the basis for delay. While the Court has been responsive in its promulgation of General Order 24, which allowed a suspension of proceedings while medical records were completed, the committee believes it necessary to set a clear standard of petition contents. The committee has, therefore, set forth a list of records (listed below at Paragraph (5) that must be included and has retained the broader list of records that should also be made available if needed for considering the petition for compensation. The committee anticipates that petitions for compensation can be reviewed by the Court for completeness under these standards and that the statutory time frame for compensation proceedings will commence from the receipt of a petition containing the specified materials. As specified below in Paragraph (4), materials not available to petitioners at the time of filing the petition may be described in lieu of provision, although the committee would expect respondents and the Court to evaluate the compensability of a petition on the basis of information received. The committee does not intend to preclude filings from being deemed adequate because of minor, inadvertent omissions or when material is unavailable to the petitioner.

Paragraph (2) provides technical clarification of the ability of a petitioner with a civil court action pending to enter the compensation system. Subparagraph (A) clarifies that a petitioner must petition to have his or her action dismissed and may not simply allow the action to lie dormant during the compensation proceeding. Subparagraph (B) clarifies that a plaintiff in such an action whose action is still pending may not enter the compensation system. In keeping with the purposes of the Act and this legislation, the committee intends that plaintiffs in pending actions who wish to have such actions dismissed without prejudice so that they may enter the compensation system be allowed to do so without prejudice or other disincentives.

Paragraph (3) amends the Act's restrictions on entry into the compensation system. The Act prohibits anyone who brings a civil action after the effective date (October 1, 1988) from entering the compensation system. The committee has received information, however, that the Claims Court did not accept petitions for compensation until November 15, 1988. Persons who chose between a civil action and a petition during that 6-week period did not, therefore, have a true choice. Rather than statutorily barring such persons from the system, the committee intends to allow such persons to petition to have their civil actions dismissed (as provided in Section 2111(a)(5)) and to enter into the compensation system.

Paragraph (4) inserts a new paragraph to allow petitions to be brought by persons who had appeals of civil actions pending on the effective date of the Act. Under the Act, plaintiffs in a civil action who were denied damages before October 1, 1988, are allowed to file petitions for compensation. Similarly, plaintiffs in a civil action pending on October 1, 1988, may petition to have such action dismissed before judgment and may file petitions for compensation. Conversely, plaintiffs who have civil actions pending on October 1, 1988 and do not have their civil actions dismissed may not file a compensation petition. Finally, if a person brings a civil action after deadline (originally October 1, 1988; amended by Paragraph (3) above to be November 15, 1988), he or she may not file a compensation petition. In crafting these original transition rules, the committee did not anticipate the situation in which a person had an appeal of a civil action pending on October 1, 1988, and did not have such action dismissed. The legislation would amend the Act to allow such a person to file a petition for compensation if damages were ultimately denied in the civil action (whether in the original trial verdict or in the appeals of the trial verdict).

Paragraph (5) adds a new paragraph to the Act to specify (as described above at Paragraph (1) the minimum supportive materials that must be supplied in order to initiate a compensation proceeding. Minimum materials include maternal and infant doctor and hospital records and, if applicable, autopsy results. The legislation would also add a new paragraph to allow petitioners to submit an identification of records that are unavailable (and the reasons for their unavailability) in lieu of submitting the materials. The committee intends for the parties and the Court to construe this provision broadly so as to require the submission of a meaningful file of information but not so as to hold up proceedings unreasonably if petitioner makes a good faith effort to supply records and name unavailable ones. The committee intends that petitioner also make every effort to continue to obtain unavailable records and that petitioners submit records as they become available.

Paragraph (6) adds a new subsection to Section 2111(c) of the Act regarding the timing of submissions and the bifurcation of proceedings. The committee intends that the Special Master and the Court make efforts to allow compensation proceedings to begin on the issue of *whether* compensation is to be awarded without requiring petitioners to submit information that is needed only to decide *how much* compensation is to be awarded and without requiring respondents to evaluate such information, and the committee expects that the Master will initially restrict inquiry to the question of whether to award compensation. The committee believes that this structure, similar to that established for vaccine civil actions by the Act, will serve petitioners, respondents, and the Court well by allowing all participants to avoid needless documentation of issues that may never arise.

Paragraph (7) is a technical amendment.

Paragraph (8) makes a conforming amendment to make a reference parallel to that established by Paragraph (2) above.

(c) *Special Masters.* Section 4402(c) revises the provisions of the Act regarding the authorities of Special Masters. The Act provides the Master with powers to require such evidence as he or she may

need to determine whether compensation should be awarded and, if so, the amount of compensation to be awarded. The Act, however, provided these powers in a non-parallel fashion, giving all authorities in determining whether to award and not explicitly providing some in determining how much the award should be and setting a standard of "appropriate" in one authority and "reasonable and necessary" in others.

The legislation revises these authorities to make them parallel and consistent. All authority granted to the Master may be exercised in the determination of whether compensation should be awarded and in the determination of how much the award should be. All authority is to be used when reasonable and necessary to achieve these results.

In addition to these changes, the legislation also makes two substantive changes in the authorities of the Masters. First, the legislation has limited hearings to those requested by one of the parties and found to be reasonable and necessary by the Master. The committee does not intend to restrict the Master's ability to gather relevant oral and written materials and has made no similar limitation on the authority to require evidence, information, or testimony. The committee is, however, concerned that the routine use of hearings as a method of gathering such information may produce unnecessary formality in the gathering of such information and may tend to create an adversary process rather than a no-fault compensation proceeding.

Second, the legislation amends the Act to require—rather than simply permit—the Master to prepare and submit proposed findings of fact and conclusions of law to the Court.

The committee reiterates its concern that these authorities not be used to re-create an adversarial process before the Special Masters. The system is intended to allow the proceedings to be conducted in what has come to be known as an "inquisitorial" format, with the Master conducting discovery (as needed), cross-examination (as needed), and investigation. As was stated in the Report accompanying the original Act, "In order to expedite the proceedings, the power of the Special Master is intended to replace the usual rules of discovery in civil actions in Federal courts." The parties are, of course, free to request that the Master develop the record by obtaining necessary information. (For example, the Master might be asked to subpoena further records.)

The committee also believes that the Masters may, in some cases, be well-advised to retain independent medical experts to assist in the evaluation of medical issues associated with eligibility for compensation and the amounts of compensation to be awarded. In cases where petitioners assert a theory of vaccine causation of injury and respondents claim other causation, the Master may find it most expeditious to receive outside advice rather than attempt a full adversarial proceeding on the questions of causation. The Act authorizes such action by the Master and the committee would encourage its use as appropriate.

(d) *De Novo Proceedings.* Section 4402(d) clarifies that the Claims Court, in acting upon the recommendations of the Master, may receive further evidence in addition to that contained in the Master's report. The committee recognizes that the regrettable lack of repre-

sentation on behalf of DOJ and DHHS has, in some cases, resulted in the omission of useful evidence from the record. The committee intends that the Court, as appropriate, exercise its authority to complete records and to receive additional evidence. The committee does not, however, anticipate that this authority will be generally used in pending cases or frequently required in future cases.

(e) *Time for Judgment.* Section 4402(e) extends the time period for the Court to make its judgment on petitions relating to vaccines administered before October 1, 1988. The committee recognizes that in the initial implementation, delays have arisen in proceedings on early cases. Rather than holding the Court to unrealistic time frames, the committee has chosen to allow an extra 6 months to deal with the backlog of pre-enactment cases. The committee intends that this extra time be used only as necessary and not be used as a general delay to cases that might quickly be resolved.

(f) *Table.* Section 4402(f) makes a technical correction in references in the Vaccine Injury Table.

(g) *Compensation.* Paragraph (1) of Section 4402(g) makes technical changes to clarify the compensation that is to be allowed in cases involving injuries associated with a vaccine administered before the effective date of the Act (October 1, 1988). The committee is aware that there may be some confusion about the allowable compensation and intends that pre-enactment injuries be eligible for actual unreimbursable expenses incurred from the date of judgment (as provided in 2115(a)(1)(A) of the Act), death benefits (as provided in 2115(1)(2)) and a total amount up to $30,000 for the combined amounts of lost earnings (as provided in 2115(a)(3)), pain and suffering (as provided in 2115(a)(4)), and attorneys' fees and costs (as provided in 2115(e)). This represents no change in policy from the Act and is only intended to clarify the amount of damages.

Paragraph (2) of Section 4402(g) makes technical changes to clarify that the Claims Court award for amounts to cover attorneys' fees and costs is to be included after proceedings are complete.

(h) *Technical.* Section 4402(h) makes technical amendments to clarify that judgments entered are final judgments and to remove any ambiguity that the Act contemplated different points in the proceeding by its use of different terms. The committee does not intend to alter the effect of the Act but simply to make clear that the stay is to continue in effect until all appeals, if any, are resolved. Similarly, under Section 2121(a), an election by the petitioner need not be made until 90 days after all appeals, if any, are resolved.

(i) *Vaccine Information.* Section 4402(i) amends the Act's requirement of vaccine information materials to be provided to parents and guardians of children receiving immunizations. The Act provided for these materials to include a summary of relevant State and Federal laws on vaccination requirements. The legislation would substitute a summary of relevant Federal recommendations concerning the schedule of childhood immunizations.

(j) *Authorizations.* The Act provides no authorizations for administrative expenses related to the Compensation Program. Section 4402(j) authorizes funds to be used for administrative expenses for fiscal year 1990 and 1991 for DHHS, DOJ, and the Claims Court.

The committee is concerned by the inadequate support and personnel that DHHS and DOJ have committed to the system and is disturbed by the failure of DOJ to make appearances and act as a representative of DHHS in these cases and the committee expects DOJ to return to its responsibilities to represent the government in these cases (to the extent that the government may require representation). The committee does not intend that these funds be used to substitute existing resources devoted to these programs and expects DHHS and DOJ to continue to provide at least the current level of support in addition to these authorizations. As is made clear by other sections of this report, the committee also does not intend that any of the three recipients of these authorized funds use them to prolong proceedings in a legalistic or unnecessarily detailed manner. These funds are provided to expedite the review and processing of information in order to simplify proceedings and allow for a quick resolution of claims.

(k) *Rules Changes.* Section 4402(k) requires the Claims Court to review its rules for vaccine proceedings and to make revisions in the rules in a manner conforming to the applicable law regarding issuance of rules and opportunity for public comment and consultation. The committee intends that the revisions provide for a nonadversarial, expeditious, and informal proceedings. The committee has received reports that the current rules of the Court are formal rules akin to those of the Federal Courts for civil litigation. The committee once more reiterates its desire that the Court make vaccine proceedings as swift and uncomplicated as possible.

(l) *Study.* Section 4402(l) requires that DHHS evaluate the National Vaccine Injury Compensation Program and report the results to the Committee on Energy and Commerce of the House and Committee on Labor and Human Resources of the Senate.

(m) *Effective Date.* Section 4402(m) provides that the changes made by these amendments apply to petitions filed after the date of enactment of this section. The committee intends that the Court interpret this provision broadly, allowing itself and the parties to use this legislation to expedite proceedings and to clarify confusion that may exist in petitions already filed. The committee recognizes that some confusion could arise, however, if rules changes were strictly enforced in pending claims and has provided this effective date to allow the Court to administer proceedings equitably.

Sec. 4403—Study by General Accounting Office with respect to Loss by Retired Individuals of Health Benefits due to Liquidation of Employer in Bankruptcy

Most Americans are insured through their employer by private group health insurance. The Consolidated Budget Reconciliation Act of 1985 included a requirement that employers with 20 or more employees that offer a group health insurance plan offer qualified employees and their families the option of continued health insurance at group rates when faced with the loss of coverage because of certain events. In the Omnibus Reconciliation Act of 1986, Congress added as a "qualifying event" a proceeding in a case under the bankruptcy provisions of Title 11 of the U.S. Code commencing on or after July 1, 1986.

Thus, under chapter 11 bankruptcy, employees' health benefits are somewhat protected. However, under chapter 7 bankruptcy, companies liquidate and pay off certain creditors, but employees' and retirees' continued health benefits have no guaranteed protection.

The committee directs the General Accounting Office to conduct a study to identify options for providing health benefits for any retired individual whose employer-provided health benefits are terminated because the employer receives a discharge under chapter 7 of Title 11, U.S. Code. The committee requests that the GAO examine a range of approaches and determine for each method the cost to the Federal and State governments; the cost to individuals; the extent of benefits to be provided; and the administrative structure required and its cost.

In addition, the committee has noted the increasing trend toward early retirement and the fact that one third of all retirees are now under age 65. Many companies in recent years have increased beneficiary cost-sharing and reduced benefits in an effort to limit cost increases to the former employers. The committee is directing GAO to also examine the extent to which employer-provided health benefits for retirees have been reduced since 1984 and to project trends in the near future.

APPENDICES

The following three appendices set forth specifications for the implementation of section 4001 of the committee bill. Section 4001 establishes a fee schedule, using a resource-based relative value scale, for making payments for physician services under Medicare. An explanation of how these appendices are to be used is set forth in the section-by-section analysis for section 4001.

Appendix A.—LIST OF PROCEDURES AND RELATIVE VALUES

Code and description	Relative value	Physician work component (percent)	Practice expense component (percent)
Group A: Procedure codes			
19160 Removal of breast tissue	24.5	51	49
19162 Remove breast tissue: modes	56	48	52
19180 Removal of breast	34.7	51	49
19182 Removal of breast tissue	36.5	50	50
19200 Extensive breast surgery	62	47	53
19220 Extensive breast surgery	66	48	52
19240 Extensive breast surgery	61	49	51
20550 Injection treatment	2.22	62	38
20600 Drainage joint/bursa/cyst	2.39	65	35
20605 Drainage joint/bursa/cyst	2.80	66	34
20610 Injection/drain joint/bursa	2.83	65	35
27125 Revise hip with prosthesis	86	39	61
27126 Revise hip with prosthesis	90	40	60
27127 Revise hip with prosthesis	105	38	62
27130 Total hip joint replacement	132	39	61
27132 Total hip joint replacement	156	37	63
27134 Revise hip joint replacement	156	41	59
27137 Revise hip joint component	121	43	57
27138 Revise hip joint component	120	44	56
27230 Treat fracture of femur	18.3	50	50
27232 Treat fracture of femur	41.0	48	52
27234 Treat fracture of femur	107	50	50
27235 Repair of femur fracture	80	44	56
27236 Repair of femur fracture	80	46	54
27238 Treatment of femur fracture	24.0	51	49
27240 Treatment of femur fracture	45.3	48	52
27242 Repair of femur fracture	70	53	47
27244 Repair of femur fracture	79	47	54
27246 Treatment of femur fracture	20.6	48	52
27248 Repair of femur fracture	60	52	48
28290 Correction of bunion	21.0	38	62
28292 Correction of bunion	29.8	37	63
28293 Correction of bunion	33.5	37	63
28294 Correction of bunion	33.0	37	63
28296 Correction of bunion	34.2	39	61
28297 Correction of bunion	34.6	34	66
28298 Correction of bunion	26.4	37	63
28299 Correction of bunion	42.5	35	65
29870 Knee arthroscopy	14.5	38	62

Appendix A.—LIST OF PROCEDURES AND RELATIVE VALUES—Continued

Code and description		Relative value	Physician work component (percent)	Practice expense component (percent)
29871	Knee arthroscopy/drainage	26.0	38	62
29872	Knee arthroscopy/drainage	28.2	36	64
29874	Knee arthroscopy/surgery	32.3	32	68
29875	Knee arthroscopy/surgery	40.7	32	68
29876	Knee arthroscopy/surgery	41.9	33	67
29877	Knee arthroscopy/surgery	48.1	25	75
29879	Knee arthroscopy/surgery	47.9	31	69
29880	Knee arthroscopy/surgery	62	27	73
29881	Knee arthroscopy/surgery	46.7	31	69
29882	Knee arthroscopy/surgery	45.3	34	66
29884	Knee arthroscopy/surgery	30.5	36	64
29886	Knee arthroscopy/surgery	39.3	32	68
29887	Knee arthroscopy/surgery	33.8	33	67
29889	Knee arthroscopy/surgery	72	41	59
31000	Irrigation maxillary sinus	2.09	39	62
31001	Irrigation maxillary sinuses	3.07	35	66
31002	Irrigation sphenoid sinus	1.91	45	55
31020	Exploration maxillary sinus	10.6	44	56
31021	Exploration of sinuses	16.3	41	59
31030	Exploration maxillary sinus	36.0	39	61
31031	Exploration of sinuses	51	40	61
31032	Explore sinus: remove polyps	37.1	41	60
31033	Enter sinuses, remove polyps	47.0	39	61
31360	Removal of larynx	93	46	54
31365	Removal of larynx	128	45	55
31367	Partial removal of larynx	96	46	54
31368	Partial removal of larynx	125	48	52
31500	Endotracheal intubation	6.8	59	41
32000	Drainage of chest	8.8	72	28
32020	Treatment of collapsed lung	13.5	52	48
32035	Exploration of chest	36.6	51	49
32036	Exploration of chest	39.8	52	48
32440	Removal of lung	110	47	53
32480	Partial removal of lung	101	47	53
32485	Partial removal of lung	116	49	51
32490	Partial removal of lung	121	49	51
32500	Partial removal of lung	80	47	53
32520	Remove lung ad revise chest	110	47	53
32522	Remove lung and revise chest	113	48	52
32525	Remove lung and revise chest	137	47	53
33206	Insertion of heart pacemaker	45.0	29	71
33207	Insertion of heart pacemaker	44.0	31	69
33208	Insertion of heart pacemaker	57	31	69
33210	Insertion of heart electrode	13.7	31	70
33212	Insertion of pulse generator	25.7	31	69
33216	Revision implanted electrode	21.6	34	66
33218	Repair pacemaker electrodes	17.9	34	66
33219	Repair of pacemaker	25.0	34	66
33232	Removal of pacemaker	15.5	39	62
33405	Replacement of aortic valve	168	38	62
33510	Coronary artery bypass	141	34	66
33511	Coronary arteries bypass	168	35	65
33512	Coronary arteries bypass	184	35	65
33513	Coronary arteries bypass	195	36	64
33514	Coronary arteries bypass	202	36	64
33516	Coronary arteries bypass	212	35	65
35001	Repair defect of artery	87	47	53
35011	Repair defect of artery	78	47	53

Appendix A.—LIST OF PROCEDURES AND RELATIVE VALUES—Continued

Code and description	Relative value	Physician work component (percent)	Practice expense component (percent)
35013 Repair artery rupture, arm	94	48	52
35021 Repair defect of artery	99	48	52
35022 Repair artery rupture, chest	45.8	50	50
35045 Repair defect of arm artery	69	46	54
35081 Repair defect of artery	128	45	55
35082 Repair artery rupture: aorta	144	44	57
35091 Repair defect of artery	140	47	53
35092 Repair artery rupture, belly	156	46	54
35102 Repair defect of artery	136	46	54
35103 Repair artery rupture: groin	149	45	55
35111 Repair defect of artery	93	52	48
35112 Repair artery rupture, spleen	96	42	58
35121 Repair defect of artery	95	47	53
35122 Repair artery rupture, belly	108	41	59
35131 Repair defect of artery	81	48	52
35132 Repair artery rupture, groin	115	46	54
35141 Repair defect of artery	88	45	55
35142 Repair artery rupture, thigh	95	47	53
35151 Repair defect of artery	88	47	53
35152 Repair artery rupture, knee	104	47	53
35161 Repair defect of artery	68	45	55
35301 Rechanneling of artery	83	39	61
35311 Rechanneling of artery	105	38	62
35321 Rechanneling of artery	65	42	58
35331 Rechanneling of artery	66	42	58
35341 Rechanneling of artery	76	42	58
35351 Rechanneling of artery	75	41	59
35355 Rechanneling of artery	84	40	60
35361 Rechanneling of artery	96	39	61
35363 Rechanneling of artery	111	39	61
35371 Rechanneling of artery	71	38	62
35372 Rechanneling of artery	71	38	62
35381 Rechanneling of artery	76	41	59
39400 Visualization of mediastinum	30.1	47	53
44120 Removal of small intestine	64	49	51
44125 Removal of small intestine	65	51	49
44130 Bowel to bowel fusion	59	49	51
44140 Partial removal of colon	73	48	52
44141 Partial removal of colon	75	49	51
44143 Partial removal of colon	84	48	52
44144 Partial removal of colon	79	49	51
44145 Partial removal of colon	86	49	51
44146 Partial removal of colon	97	47	53
44147 Partial removal of colon	93	50	50
44150 Removal of colon	94	47	53
44151 Removal of colon/ileostomy	102	51	49
44152 Removal of colon/ileostomy	99	47	53
44153 Removal of colon/ileostomy	102	46	54
44155 Removal of colon	106	49	51
44156 Removal of colon/ileostomy	96	44	56
44160 Removal of colon	78	47	53
44950 Appendectomy	29.6	45	55
44960 Appendectomy	35.1	46	54
45378 Diagnostic colonoscopy	20.4	35	66
45379 Colonoscopy	22.3	36	64
45380 Colonoscopy and biopsy	22.8	34	66
45382 Colonoscopy, control bleeding	28.1	35	65
45383 Colonoscopy, lesion removal	24.6	35	65

Appendix A.—LIST OF PROCEDURES AND RELATIVE VALUES—Continued

Code and description		Relative value	Physician work component (percent)	Practice expense component (percent)
45385	Colonoscopy: lesion removal	30.7	33	67
47600	Removal of gallbladder	47.4	45	56
47605	Removal of gallbladder	51	45	55
47610	Removal of gallbladder	59	46	54
47612	Removal of gallbladder	87	46	54
47620	Removal of gallbladder	69	46	46
49500	Repair inguinal hernia	27.4	40	60
49505	Repair inguinal hernia	27.4	37	63
49510	Repair hernia: remove testis	29.5	38	62
49515	Repair inguinal hernia	30.9	39	61
49520	Rerepair inguinal hernia	31.8	37	63
49525	Repair inguinal hernia	33.7	35	65
49530	Repair incarcerated hernia	30.9	38	62
49535	Repair strangulated hernia	29.7	40	60
49540	Repair lumbar hernia	31.3	39	61
49550	Repair femoral hernia	28.3	37	63
49552	Repair femoral hernia	29.7	41	59
49555	Remove femoral hernia	30.9	39	61
49560	Repair abdominal hernia	33.3	38	63
49565	rerepair abdominal hernia	37.1	38	62
49570	Repair epigastric hernia	20.6	40	60
49575	Repair epigastric hernia	27.7	41	59
49580	Repair umbilical hernia	22.4	40	60
49581	Repair umbilical hernia	25.7	37	63
49590	Repair abdominal hernia	28.8	38	62
50590	Fragmenting of kidney stone	55	49	51
52340	Cystoscopy and treatment	22.3	55	45
52500	Revision of bladder neck	43.8	47	53
52601	Prostatectomy (TUR)	62	48	52
52606	Control postop bleeding	14.2	58	42
52612	Prostatectomy, first stage	57	53	47
52614	Prostatectomy, second stage	34.4	52	48
52620	Remove residual prostate	26.3	58	42
52630	Remove prostate regrowth	57	48	52
52640	Relieve bladder constructure	31.9	49	51
52650	Prostatectomy	44.4	44	56
58102	Curettage of uterus lining	4.45	42	58
58103	Menstrual extraction	4.98	46	54
58120	Dilation and curettage	15.2	42	58
58150	Total hysterectomy	54	39	61
58152	Total hysterectomy	62	40	60
58180	Partial hysterectomy	50	43	57
58200	Extensive hysterectomy	66	38	62
58210	Extensive hysterectomy	90	39	61
58260	Vaginal hysterectomy	52	36	64
58265	Hysterectomy & vagina repair	56	39	61
58267	Hysterectomy & vagina repair	58	37	64
58270	Hysterectomy & vagina repair	59	38	62
58275	Hysterectomy, revise vagina	62	43	57
58280	Hysterectomy, revise vagina	61	41	59
58285	Extensive hysterectomy	71	39	61
63001	Removal of spinal lamina	97	45	55
63003	Removal of spinal lamina	94	44	56
63005	Removal of spinal lamina	93	44	56
63010	Removal of spinal lamina	96	42	58
63011	Removal of spinal lamina	65	46	54
63015	Removal of spinal lamina	117	43	57
63016	Removal of spinal lamina	119	44	56

Appendix A.—LIST OF PROCEDURES AND RELATIVE VALUES—Continued

Code	Code and description	Relative value	Physician work component (percent)	Practice expense component (percent)
63017	Removal of spinal lamina	112	43	57
63020	Neck spine disk surgery	83	46	54
63021	Neck spine disk surgery	104	42	58
63030	Low back disk surgery	80	46	54
63031	Low back disk surgery	99	43	57
63035	Added spinal disk surgery	29.7	51	49
63040	Neck spine disk surgery	109	42	58
63042	Low back disk surgery	104	44	56
64716	Revision of cranial nerve	30.0	32	68
64718	Revise ulmar nerve at elbow	28.8	35	65
64719	Revise ulmar nerve at wrist	16.9	34	66
64721	Revise median nerve at wrist	22.7	33	67
65850	Incision of eye	57	35	65
65855	Laser surgery of eye	42.7	35	65
66840	Removal of lens material	42.8	48	52
66850	Removal of lens material	73	39	61
66920	Extraction of lens	58	41	59
66930	Extraction of lens	49.5	49	51
66940	Extraction of lens	62	45	55
66983	Remove cataract: insert lens	85	39	61
66984	Remove cataract: insert lens	82	42	59
66985	Insert lens prosthesis	56	42	58
67107	Repair detached retina	95	42	59
67108	Repair detached retina	145	41	59
67208	Treatment of retinal lesion	43.4	37	63
67210	Treatment of retinal lesion	40.4	36	64
67218	Treatment of retinal lesion	53	41	59
67227	Treatment of retinal lesion	44.7	38	62
67228	Treatment of retinal lesion	40.4	37	63
69631	Repair eardrum structures	72	47	54
69632	Repair eardrum structures	81	48	52
69633	Repair eardrum structures	80	49	51
69635	Repair eardrum structures	84	47	53
69636	Repair eardrum structures	89	49	51
69637	Repair eardrum structures	100	43	57
69641	Revise middle ear & mastoid	90	47	53
69642	Revise middle ear & mastoid	93	49	51
69643	Revise middle ear & mastoid	97	48	52
69644	Revise middle ear & mastoid	110	47	53
69645	Revise middle ear & mastoid	95	48	52
69646	Revise middle ear & mastoid	103	46	54
76700	Echo exam of abdomen	6.9	42	58
76705	Echo exam of abdomen	4.59	45	55
76770	Echo exam of abdomen	6.2	42	58
76775	Echo exam abdomen back wall	4.78	43	57
92225	Extended ophthalmoscopy, new	2.09	44	56
92226	Extended ophthalmoscopy	1.90	42	58
92230	Ophthalmoscopy/angioscopy	3.23	43	57
92235	Ophthalmoscopy/angiography	7.8	44	56
92250	Ophthalmoscopy; fundus photo	1.56	45	55
92265	Eye muscle evaluation	1.25	24	76
92270	Electro-oculography	2.14	23	77
92275	Electroretinography	4.07	21	79
92280	Special eye evaluation	3.13	21	79
92283	Color vision examination	1.23	25	75
92284	Dark adaptation eye exam	1.72	20	80
92285	Eye photography	1.06	22	78
92286	Internal eye photography	4.59	23	77

Appendix A.—LIST OF PROCEDURES AND RELATIVE VALUES—Continued

Code and description		Relative value	Physician work component (percent)	Practice expense component (percent)
92287	Internal eye photography	4.12	18	82
93000	Electrocardiogram: complete	1.62	34	66
93005	Electrocardiogram: tracing	0.68	35	66
93010	Electrocardiogram report	0.61	39	61
93012	Transmission of ecg	1.61	35	65
93014	Report on transmitted ecg	0.88	39	61
93015	Cardiovascular stress test	6.4	35	65
93017	Cardiovascular stress test	2.29	39	61
93018	Cardiovascular stress test	3.17	40	60
93024	Cardiac drug stress test	5.6	42	58
93040	Rhythm ecg with report	0.81	39	61
93041	Rhythm ecg, tracing	0.55	42	58
93042	Rhythm ecg: report	0.51	46	54
93045	Special ecg	1.18	36	64
93501	Right heart catherization	17.2	36	64
93503	Right heart catherization	13.7	35	65
93505	Biopsy of heart lining	15.2	37	63
93510	Left heart catheterization	20.6	32	68
93511	Left heart catheterization	13.2	35	65
93524	Left heart catheterization	17.5	40	60
93526	Rt and lt heart cath	27.1	35	65
93527	Rt and lt heart cath	26.1	36	64
93528	Rt and lt heart cath	21.7	33	67
Group B: Evaluation and management codes				
90000	Office visit, new, brief			
90010	Office visit, new, limited			
90015	Office visit, new, intermediate			
90017	Office visit, new, extended			
90020	Office visit, new, comprehensive			
90030	Office visit, minimal			
90040	Office visit, brief			
90050	Office visit, limited			
90060	Office visit, intermediate			
90070	Office visit, extended			
90080	Office visit, comprehensive			
90100	Home visit, new, brief			
90110	Home visit, new, limited			
90115	Home visit, new, intermediate			
90117	Home visit, new, extended			
90130	Home visit, minimal			
90140	Home visit, brief			
90150	Home visit, limited			
90160	Home visit, intermediate			
90170	Home visit, extended			
90200	Hospital care, new, brief			
90215	Hospital care, new, intermediate			
90220	Hospital care, new, comprehensive			
90225	Hospital care, new, newborn90240			
90240	Hospital care, brief			
90250	Hospital visit, limited			
90260	Hospital visit, intermediate			
90270	Hospital visit, extended			
90280	Hospital visit, comprehensive			
90282	Normal newborn care hospital			
90292	Hospital discharge day			
90300	Care facility visit, brief			
90315	Care facility visit, intermediate			
90320	Care facility visit, comprehensive			

Appendix A.—LIST OF PROCEDURES AND RELATIVE VALUES—Continued

Code	Code and description	Relative value	Physician work component (percent)	Practice expense component (percent)
90340	Care facility visit, brief			
90350	Care facility visit, limited			
90360	Care facility visit, intermediate			
90370	Care facility visit, extended			
90400	Care facility visit, brief			
90410	Care facility visit, limited			
90415	Care facility visit, intermediate			
90420	Care facility visit, comprehensive			
90430	Care facility visit, minimal			
90440	Care facility visit, brief			
90450	Care facility visit, limited			
90460	Care facility visit, intermediate			
90470	Care facility visit, extended			
90500	Emergency care, new, minimal			
90505	Emergency care, new, brief			
90510	Emergency care, new, limited			
90515	Emergency care, new, intermediate			
90517	Emergency care, new, extended			
90520	Emergency care, new, comprehensive			
90530	Emergency care, minimal			
90540	Emergency care, brief			
90550	Emergency care, limited			
90560	Emergency care, limited			
90570	Emergency care, extended			
90580	Emergency care, comprehensive			
90600	Limited consultation			
90605	Intermediate consultation			
90610	Extended consultation			
90620	Comprehensive consultation			
90630	Complex consultation			
90640	Brief followup consultation			
90641	Limited followup consultation			
90642	Intermediate followup consultation			
90643	Complex followup consultation			
90650	Second or third opinion			
90651	Second or third opinion			
90652	Second or third opinion			
90653	Second or third opinion			
90654	Second or third opinion			
90750	Preventive medicine, adult			
90751	Preventive medicine, age 12–17			
90752	Preventive medicine, age 5–11			
90753	Preventive medicine, age 1–4			
90754	Preventive medicine, infant			
90755	Infant care to one year			
90757	Newborn care not in hospital			
90760	Preventive medicine, adult			
90761	Preventive medicine, age 12–17			
90762	Preventive medicine, age 5–11			
90763	Preventive medicine, age 1–4			
90764	Preventive medicine, infant			
99062	Emergency care services			
99064	Emergency care services			
99065	Emergency care services			
99160	Critical care, each hour			
99162	Critical care, added thirty minute			
99171	Critical care, followup			
99172	Critical care, followup			

Appendix A.—LIST OF PROCEDURES AND RELATIVE VALUES—Continued

Code and description	Relative value	Physician work component (percent)	Practice expense component (percent)
99173 Critical care, followup			
99174 Critical care, followup			
Number of codes	389		

Appendix B.—CALCULATION OF CONVERSION FACTOR

This appendix specifies the data base, adjustments, and behavioral parameters to be used by the Secretary of Health and Human Services in calculating the conversion factor for 1990 under section 4001(a)(5) of the bill in a manner that will maintain budget neutrality after taking into account changes in the volume of services that might occur as a response to payment changes specified for 1990 in this section of the bill.

The model differentiates between "first order" or prebehavioral estimates of the conversion factor and "second order" of postbehavioral calculations. First order estimates yield a conversion factor that takes into account the adjustments in prevailing charges that would be made in each of the services listed in appendix A. However, the first order estimate does not take into account changes in the mix, intensity, and volume (hereinafter simply referred to as volume) of services that might result from behavioral changes that occur as a result of these adjustments. The purpose of the second order adjustment is to account for such changes in volume as necessary to maintain budget neutrality.

Behavioral changes could reflect altered demand for services by patients or changes in demand inducement by physicians in response to new Medicare payment amounts and new limits on actual charges. Estimated behavioral responses are not symmetric, however. Practices whose receipts would fall because of a payment change by Medicare would have a larger offsetting behavioral response than would practices whose receipts would increase. In particular, the offset to a reduction in payments is larger (55.5 percent) than the offset to an increase in payments (37.5 percent). In application, these offsets are adjustments to the underlying rate of growth in the volume of Medicare services per enrollee, so that volume growth would temporarily accelerate for practices that were "losers" under the payment change, while growth would decelerate for "winners."

This appendix consists of three sections. The first section provides instructions on selecting and adjusting the data base to be used in simulating the payment change. The second section contains instructions on how to calculate the first-order conversion factor. The third section describes the iterative process used to adjust the first-order conversion factor to take account of behavioral responses so as to achieve budget neutrality.

I. Data Selection and Adjustment

The data base to be used is the part B Medicare Annual Data provider (BMAD III) file for calendar year 1987. This is a 5-percent sample of all Medicare providers. Two carriers—for Railroad Retirees and for Puerto Rico—are eliminated because of difficulties in

defining appropriate cost indexes for the claims they process. In addition, all supplier specialties are eliminated because they are unaffected by the payment changes here.

Although only the services listed in appendix A will be affected by the payment changes to be simulated here, all Medicare services provided by each practice must be retained in order to estimate behavioral responses appropriately. Entire physician practices may be eliminated, however, when they have no claims for the affected services. This means that radiologists and anesthesiologists may be eliminated, among others.

Three kinds of adjustments to this data base are made. First, prevailing charges are added to all records. Second, the data are adjusted to reflect projected participation rates and assignment rates. Finally, prevailing charges, submitted charges, and allowed charges are adjusted to reflect values as projected for 1990. Each of these adjustments is explained in detail below.

Imputing Prevailing Charges. The controlling prevailing charge during 1987 is added to each record. This can be completed in the sequence described below, but in each stage the process is constrained so that the imputed prevailing charge is greater than or equal to the allowed charge. Further, adjustment is made for the 4 percent prevailing charge differential that existed in 1987 between participating and nonparticipating physicians. For example, if an imputed prevailing charge for a nonparticipating practice is obtained from a participating practice, the value imputed is 96 percent of the value obtained from the participating practice. Finally, for assistants at surgery (type of service 8), the prevailing charge is set at 20 percent of the prevailing charge for surgery (type of service 2), separately by locality, specialty, service, and participating status.

First, the prevailing charge for each record is set to the allowed charge when the record's payment indicator shows that payment was set by the prevailing charge. Second, prevailing charge values for records still without a prevailing charge are imputed from other records for the same service, locality, and specialty. Where this fails, prevailing charge values are imputed from other records for the same service and locality, using the specialty most likely to provide the service. Where this fails, matching prevailing charge values from the prevailing charge file (BMAD II) applicable during calendar year 1987 are imputed. If none of these methods succeeds, the prevailing charge is set equal to the allowed charge.

Adjusting Participation and Assignment Rates. Practice participation rates are adjusted so that 60 percent of allowed charges are attributed to participating practices. To do this, records for practices with any participating claims are altered so that all claims submitted by those practices are identified as participating. If this is insufficient to reach the target, then nonparticipating practices are randomly reassigned as participating practices until those practices categorized as participating account for 60 percent of allowed charges. This can be done by assigning a 7-digit random number to each nonparticipating practice and using that random number to reclassify practices as participating ones until the target is reached.

For all records reclassified as participating, the assignment indicator is changed appropriately. Also, the associated prevailing charge is increased by dividing the original prevailing charge by 0.96.

For the remaining nonparticipating practices, another random number is assigned to each record and used to adjust assignment rates until 50 percent of all allowed charges for nonparticipating practices are assigned and 50 percent are unassigned. Because nonparticipating practices will (after the adjustment in the previous paragraph) account for 40 percent of all allowed charges, this means that 20 percent of all allowed charges will be unassigned in the adjusted data base to this point. The assignment indicator is changed appropriately on all affected records.

Adjusting Charges. Appropriate adjustments to reflect projected 1990 charges differ for participating and nonparticipating practices, as redefined above.

For participating practices:

A. Prevailing charges are reduced for selected procedures (denoted hereinafter as OP codes) pursuant to Public Law 100–203 (OBRA–87, section 4045). The affected procedures, and the national average prevailing charges used to calculate the reductions, are listed in table 2 of section 5254 of the Medicare part B Carriers' Manual, part 3, Claims Process. The appropriate reductions are calculated for each record using the formulas below, where MEAN denotes the national average prevailing charge for the service and PC87 and PC88 denote the prevailing charge for 1987 and 1988, respectively.

RATIO = Min(1.5, PC87/MEAN);

If PC87 < .85*MEAN then PC88 = PC87;

Else if PC87 > .85*MEAN and if .98*PC87 <= .85*MEAN then PC88 = .85*MEAN;

Else PC88= .98*PC87*[1−(3/13)*(RATIO−0.85)].

Then, for these records only, PC87 is redefined as:

PC87 = PC88/1.01;

so that OP records can be included with all other nonprimary services in the updates made in the following steps. This is necessary because OP services did not receive the 1 percent prevailing charge update for 1988.

B. The 1987 prevailing charges are updated to 1990 values by using the multiplicative product of the updates enacted for 1988 and 1989 in Public Law 100–203 (OBRA–87, section 4042), and enacted in the bill (section 4002) for 1990. For 1988 and 1989, the updates differ for primary care and all other services. Here, primary care services include HCPCS codes 90000–90080, 90100–90170, 90300–90370, 90400–90470, 90500–90570.

	Primary Care	Other Services
1988 update	1.036	1.010
1989 update	1.030	1.010
1990 update	1.000	1.000
Total update	1.067	1.020

C. The 1987 actual charges are increased to 1989 and 1990 values by using actual or projected values of the physician fee component of the Consumer Price Index, using the same values for primary care and other services:

1988 update	1.072
1989 update	1.073
1990 update	1.074
Total update	1.235

These are the values reported in the 1989 Trustees' Report for the Supplementary Medical Insurance fund. If different values are used to compute Medicare premiums for 1990 in the 1989 promulgation notice, those actual charge update factors will be used instead.

D. Allowed charges for 1990 are calculated for each record as the minimum of the updated prevailing charge or the customary charge (defined as the updated actual charge for 1989).

For nonparticipating practices:

E. All 1987 prevailing charges on these records are first divided by 0.96, and then step A above is replicated.

F. The new prevailing charges are multiplied by 0.95, to adjust for the 1 percent increase in the nonparticipating differential between 1987 and 1990. Then step B above is replicated to increase these adjusted prevailing charges to 1990 values.

G. Actual charges are increased to 1989 and 1990 values by using actual or projected values of the physician fee component of the Consumer Price Index as given in step C above, subject to ceilings shown below by year. The net effect of maximum allowable actual charge ceilings and OP ceilings are shown below as MAAC amounts which are service and practice specific. These ceilings were enacted in Public Law 99-509 (OBRA-86, section 9331(b)) and in Public Law 100-203 (OBRA-87, section 4045).

MAAC87 = Mean actual charge for this service by this practice in 1987.

If MAAC87 < 1.15*PC88 then
MAAC88 = Max(MAAC87+0.33*(1.15*PC88−MAAC87), 1.01*MAAC87);
Else MAAC88 = 1.01*MAAC87;
If HCPCS = OP code then MAAC88 = Min(MAAC88, 1.25*PC88+0.5*(Max(0,MAAC87−1.25*PC88)));

If MAAC88 < 1.15*PC89 then
MAAC89 = Max(MAAC88+0.5*(1.15*PC89−MAAC88), 1.01*MAAC88);
Else MAAC89 = 1.01*MAAC88;
If HCPCS = OP code then MAAC89 = Min(MAAC89, 1.25*PC89);

If MAAC89 < 1.15*PC90 then
MAAC90 = Max(1.15*PC90, 1.01*MAAC89);
Else MAAC90 = 1.01*MAAC89;
If HCPCS = OP code then MAAC90 = Min(MAAC90, 1.25*PC90);

H. Allowed charges for 1990 for each record are the minimum of the updated prevailing charge, the customary charge (defined as the updated actual charge for 1989), or the actual charge for 1990.

II. First-Order (Prebehavior) Conversion Factor

This section specifies how to calculate the first-order conversion factor described under section 4001 of the bill. The formulas here are an algebraic representation of the fee schedule specified in section 4001.

The initial (prebehavior) budget neutral conversion factor (CF1) for the reference fee schedule can be obtained algebraically from the adjusted BMAD III data as follows:

CF1 = sum of 1990 allowed amounts for all affected services under prior payment policies (that is, in the absence of implementation of section 4001, but including the MEI freeze specified in section 4002), divided by the sum over all affected services of (RV(i,k) * GPCI(j) * service frequency).

RV(i,k) denotes the relative value of service i by specialty k, which is equal to the sum of the physician work component and the practice expense component (W(i) + E(i,k)), as specified in appendix A.

GPCI(j) denotes the geographic practice cost index for locality j, which is equal to the weighted sum of cost indexes for physician work (WGPCI) and for practice expense (EGPCI), as specified in appendix C. That is, GPCI(j) may be written as:

(WGPCI(j)*W(i)/RV(i,k)) + (EGPCI(j)*E(i,k)/RV(i,k)).

Hence, the first-order reference fee schedule amount for each affected service i and locality j may be written as:

RFS1(i,j,k) = RV(i,k) * CF1 * GPCI(j);
or = RV(i,k) * [CF1*(WGPCI(j)*W(i)/RV(i,k)) + CF1*(EGPCI(j)*E(i,k)/RV(i,k))].

This is equivalent to the following, which is a more convenient formulation for obtaining the conversion factor:

RFS1(i,j,k) = CF1 * [W(i)*WPGCI(j) + E(i,k)*EGPCI(j)].

III. Second-Order (Postbehavior) Conversion Factor

This section explains how to make the second-order adjustment called for in section 4001(a)(5) to achieve budget neutrality for 1990.

The final (postbehavior) budget neutral conversion factor (CF2) is equal to:

$$CF2 = ADJ * CF1,$$

so that the final reference fee schedule amounts will be:

$$RFS2(i,j,k) = ADJ * CF1 * [W(i)*WPGCI(j) + E(i,k)*EGPCI(j)].$$

In the expression for RFS2, ADJ is a volume adjustment factor obtained by iterative simulations from the BMAD III data, as described below.

For 1990, the bill specifies that payment rates are to be set by the usual customary, prevailing, and reasonable criteria, but that prevailing rates for the affected services are to be adjusted as follows:

$$New\ PC90 = PC90 + .2*(RFS2 - PC90).$$

In this formula, RFS2 is set at whatever level necessary (via the value set for ADJ) to achieve new Medicare payment amounts for all services (not only affected services) that equal, in the aggregate, what payments would have been had the prior prevailing charge (PC90) been used instead.

Medicare payment rates under both prior prevailing charges and those set in this bill are the smallest of the customary, actual, and prevailing charges for each service. Because the bill continues current limits on actual charges—which are defined relative to prevailing charges—both actual and prevailing charges might change relative to prior law.

Aggregate payments made by Medicare will change for two reasons—changes in payment rates for affected services, and changes in the volume of all services induced by the payment rate changes. The adjustment factor (ADJ) is set so that changes due to new payment rates are just offset by changes due to volume responses, in the aggregate.

In the simulation model, the value of ADJ (initialized to a value of 1) is reduced if estimated new aggregate payments exceed prior law payments, and ADJ is increased if estimated new aggregate payments are below prior law payments. This is an iterative process repeated until equality is achieved.

More precisely, the simulation model must specify that for each service i in locality j, physicians' allowed amounts (A) and Medicare receipts (R) under prior law are:

$$A(i,j) = Min(customary, prevailing, actual)\ charges;$$
$$\text{and, if the claim is assigned: } R(i,j) = A(i,j);$$
$$\text{else: } R(i,j) = S(i,j);$$

where S(i,j) denotes the actual (submitted) charge.

New prebehavior allowed amounts (new A(i,j)) and receipts (new R(i,j)) under the bill are calculated analogously, but new prevailing

and new actual charges must be used for the calculation where appropriate (that is, for affected services).

Postbehavior values for allowed amounts and receipts are obtained as follows. First, sum up prior law (A0, R0) and prebehavior new law (A1, R1) allowed amounts and receipts for all services, separately for each practice in the data set. Then calculate postbehavior new law allowed amounts and receipts (A2, R2) for each practice as follows:

$$R2 = R1 - X^*(R1-R0); \text{ and}$$
$$A2 = A1 - X^*(R1-R0)^*A0/R0.$$

For 1991 and later years, $X = 0.375$ if $(R1-R0)$ is greater than or equal to zero; $X = 0.555$ if $(R1-R0)$ is less than zero. However, for 1990 these values for X are divided by 2, to account for the delayed implementation date of these payment changes and for the likelihood that behavioral responses to payment changes lag behind implementation of the changes.

The effect of this formulation is partially to offset the first-order impact of the payment change, both for gaining and losing practices. The behavioral parameters used in this formulation were obtained by regression analysis of Medicare claims for physicians' services in Colorado, subsequent to an abrupt and substantial realignment of prevailing charges in the late 1970's ("Volume Responses to Exogenous Changes in Medicare's Payment Rates," Technical Memorandum, August 1988, U.S. Congressional Budget Office.)

Initially, ADJ is set equal to 1; the resulting values for A0 and for A2 are summed over all practices. If the sum of A2 is greater than the sum of A0, then the value of ADJ is reduced until the sums are equal for A2 and A0. Conversely, if the initial sum of A2 is less than the sum of A0, the value of ADJ is increased until the sums are equal.

Appendix C.—GEOGRAPHIC PRACTICE COST INDEXES

State	Carrier	Locality	Name	PE Index[1]	PW Index[2]
Alabama	00510	01	Northeast Alabama	0.864	0.971
Alabama	00510	02	North Central Alabama	0.862	0.940
Alabama	00510	03	Southeast Alabama	0.863	0.945
Alabama	00510	04	Southwest Alabama	0.900	0.928
Alabama	00510	05	Montgomery, Alabama	0.903	0.962
Alabama	00510	06	Rural Alabama	0.848	0.949
Alaska	01020	01	Alaska	1.229	1.213
Arizona	01030	01	Phoenix (city), Arizona	1.045	1.006
Arizona	01030	02	Tucson (city), Arizona	1.022	0.974
Arizona	01030	05	Flagstaff (city), Arizona	0.953	0.966
Arizona	01030	07	Prescott (city), Arizona	0.953	0.966
Arizona	01030	08	Yuma (city), Arizona	0.953	0.966
Arizona	01030	99	Rural Arizona	0.981	0.974
Arkansas	00520	13	Arkansas	0.789	0.921
California	00542	01	N. Coastal Cntys, California	1.109	1.006
California	00542	02	NE Rural California	1.037	1.002
California	00542	03	Marin/Napa/Solano, California	1.219	1.024
California	00542	04	Sacramento/Surr. Cntys, California	1.123	1.052
California	00542	05	San Francisco, California	1.311	1.075
California	00542	06	San Mateo, California	1.311	1.075
California	00542	07	Oakland-Berkeley, California	1.272	1.057
California	00542	08	Stockson/Surr. Cntys, California	1.070	1.037
California	00542	09	Santa Clara, California	1.297	1.096
California	00542	10	Merced/Surr. Cntys, California	1.053	1.035
California	00542	11	Fresno/Madera, California	1.054	1.012
California	00542	12	Monterey/Santa Cruz, California	1.140	1.046
California	00542	13	Kings/Tulare, California	1.046	0.997
California	00542	14	Bakersfield, California	1.089	1.056
California	00542	15	San Bernadino/E. Central California	1.114	1.051
California	00542	27	Riverside, California	1.116	1.053
California	00542	16	Santa Barbara, California	1.110	1.024
California	02050	17	Ventura, California	1.161	1.067
California	02050	18	Los Angeles, Ca (1st of 8)	1.218	1.119
California	02050	19	Los Angeles, California (2nd of 8)	1.218	1.119
California	02050	20	Los Angeles, California (3rd of 8)	1.218	1.119
California	02050	21	Los Angeles, California (4th of 8)	1.218	1.119
California	02050	22	Los Angeles, California (5th of 8)	1.218	1.119
California	02050	23	Los Angeles, California (6th of 8)	1.218	1.119
California	02050	24	Los Angeles, California (7th of 8)	1.218	1.119
California	02050	25	Los Angeles, California (8th of 8)	1.218	1.119
California	02050	26	Anaheim-Santa Ana, California	1.239	1.092
California	02050	28	San Diego/Imperial, California	1.125	1.052
Colorado	00550	01	Colorado	0.951	0.998
Connecticut	03070	01	NW and N. Central Connecticut	1.066	1.004
Connecticut	03070	02	SW Connecticut	1.151	1.106
Connecticut	03070	03	South Central Connecticut	1.113	1.037
Connecticut	03070	04	Eastern Connecticut	1.054	0.998
Delaware	00570	01	Delaware	0.975	1.051
District of Columbia	00580	01	District of Columbia and MD/VA suburbs	1.138	1.118
Florida	00590	01	Rural Florida	0.900	0.931
Florida	00590	02	N/NC Florida cities	0.954	0.951
Florida	00590	03	Fort Lauderdale, Florida	1.030	0.986
Florida	00590	04	Miami, Florida	1.100	1.068
Georgia	13110	01	Atlanta, Georgia	0.990	0.951

Appendix C.—GEOGRAPHIC PRACTICE COST INDEXES—Continued

State	Carrier	Locality	Name	PE Index[1]	PW Index[2]
Georgia	13110	02	Small Georgia cities 02	0.878	0.923
Georgia	13110	03	Small Georgia cities 03	0.851	0.922
Georgia	13110	04	Rural Georgia	0.830	0.911
Hawaii	01120	01	Hawaii	1.086	1.006
Idaho	05130	11	South Idaho	0.930	0.934
Idaho	05130	12	North Idaho	0.913	0.929
Illinois	00621	01	Northwest, Illinois	0.926	0.948
Illinois	00621	02	Rockford, Illinois	1.059	1.019
Illinois	00621	03	De Kalb, Illinois	0.951	0.957
Illinois	00621	04	Rock Island, Illinois	0.943	0.990
Illinois	00621	05	Peoria, Illinois	1.044	1.019
Illinois	00621	06	Kankakee, Illinois	0.951	0.944
Illinois	00621	07	Quincy, Illinois	0.926	0.948
Illinois	00621	08	Normal, Illinois	0.989	0.993
Illinois	00621	09	Springfield, Illinois	0.987	0.992
Illinois	00621	10	Champaign-Urbana, Illinois	0.947	0.929
Illinois	00621	11	Decatur, Illinois	0.953	0.962
Illinois	00621	12	East St. Louis, Illinois	1.008	0.978
Illinois	00621	13	Southeast Illinois	0.926	0.948
Illinois	00621	14	Southern Illinois	0.926	0.948
Illinois	00621	15	Suburban Chicago, Illinois	1.132	1.041
Illinois	00621	16	Chicago, Illinois	1.195	1.087
Indiana	00630	01	Metropolitan Indiana	0.913	0.996
Indiana	00630	02	Urban Indiana	0.859	0.960
Indiana	00630	03	Rural Indiana	0.851	0.959
Iowa	00640	01	SE Iowa (Excl Iowa City)	0.897	0.956
Iowa	00640	02	Northeast Iowa	0.887	0.943
Iowa	00640	03	North Central Iowa	0.886	0.942
Iowa	00640	04	S. Cen. Ia (Excl Des Moines)	0.855	0.924
Iowa	00640	05	Des Moines (Polk/Warren), Iowa	0.929	0.994
Iowa	00640	06	Northwest Iowa	0.862	0.938
Iowa	00640	07	Southwest Iowa	0.865	0.935
Iowa	00640	08	Iowa City (city limits)	0.931	0.920
Kansas	00650	01	Rural kansas	0.879	0.907
Kansas	00740	04	Suburban Kansas City, Kansas	0.990	0.956
Kansas	00740	05	Kansas City, Kansas	0.990	0.956
Kentucky	00660	01	Lexington & Louisville, Kentucky	0.886	0.968
Kentucky	00660	02	Sm. cities (city limits) Kentucky	0.875	0.952
Kentucky	00660	03	Rural Kentucky	0.851	0.949
Louisiana	00528	01	New Orleans, Louisiana	1.025	0.988
Louisiana	00528	02	Shreveport, Louisiana	0.924	1.005
Louisiana	00528	03	Baton Rouge, Louisiana	0.947	0.982
Louisiana	00528	04	Lake Charles, Louisiana	0.895	0.949
Louisiana	00528	05	Monroe, Louisiana	0.871	0.959
Louisiana	00528	06	Lafayette, Louisiana	0.913	0.963
Louisiana	00528	07	Alexandria, Louisiana	0.879	0.971
Louisiana	00528	50	Rural Louisiana	0.877	0.943
Maine	21200	01	Northern Maine	0.889	0.894
Maine	21200	02	Central Maine	0.880	0.885
Maine	21200	03	Southern Maine	0.948	0.912
Maryland	00690	01	Baltimore/surr. cntys, Maryland	1.032	1.055
Maryland	00690	02	Western Maryland	0.996	1.012
Maryland	00690	03	South & E. Shore, Maryland	0.990	1.022
Massachusetts	00700	01	Massachusetts Urban	1.098	1.004
Massachusetts	00700	02	Massachusetts suburbs/rural (cities)	1.046	0.993
Michigan	00710	01	Detroit, Michigan	1.170	1.117
Michigan	00710	02	Michigan, not Detroit	1.006	1.019
Minnesota	00720	02	Northern Minnesota	0.898	0.966
Minnesota	00720	04	Southern Minnesota	0.883	0.958
Minnesota	10240	01	St. Paul-Minneapolis, Minnesota	0.990	1.028
Mississippi	10250	01	Rural Mississippi	0.814	0.920

Appendix C.—GEOGRAPHIC PRACTICE COST INDEXES—Continued

State	Carrier	Locality	Name	PE Index[1]	PW Index[2]
Mississippi	10250	02	Urban Mississippi (city limits)	0.871	0.933
Missouri	00740	01	St. Joseph, Missouri	0.906	0.900
Missouri	00740	02	North Kansas City (Clay/Platte), Missouri	0.990	0.956
Missouri	00740	03	Kansas City (Jackson County), Missouri	0.990	0.956
Missouri	00740	06	Rural NW Counties, Missouri	0.904	0.906
Missouri	11260	01	St. Louis/Lg. E. Cities, Missouri	1.015	0.976
Missouri	11260	02	Sm. E. Cities & Jefferson County, Missouri	0.955	0.947
Missouri	11260	03	Rural (Excl. Rural NW) Missouri	0.889	0.901
Montana	00751	01	Montana	0.901	0.935
Nebraska	00645	15	Omaha & Lincoln, NE	0.869	0.942
Nebraska	00645	16	Urban (Cnty Pop—25,000) NE	0.813	0.912
Nebraska	00645	17	Rural Nebraska	0.800	0.905
Nevada	01290	01	Las Vegas, et al (cities), Nevada	1.090	1.073
Nevada	01290	02	Reno, et al (cities), Nevada	1.142	1.016
Nevada	01290	03	Elko & Ely (cities), Nevada	1.041	0.969
Nevada	01290	99	Rural Nevada	1.087	1.039
New Hampshire	00780	40	New Hampshire	0.961	0.925
New Jersey	13310	01	Northern New Jersey	1.134	1.080
New Jersey	13310	02	Middle New Jersey	1.098	1.069
New Jersey	13310	03	Southern New Jersey	1.084	1.031
New Mexico	05320	05	New Mexico	0.906	0.962
New York	00801	01	Buffalo/Surr. cntys, New York	0.945	1.011
New York	00801	02	Rochester/Surr. cntys, New York	1.011	1.043
New York	00801	03	N. Central Cities, New York	0.953	0.993
New York	00801	04	Rural New York	0.939	0.976
New York	00803	01	Manhattan, New York	1.330	1.118
New York	00803	02	NYC Suburbs/Long Island, New York	1.318	1.120
New York	00803	03	Poughkpsie/N. NYC Suburbs	1.043	1.007
New York	14330	04	Queens, New York	1.330	1.118
North Carolina	13340	94	Urban (City limits), North Carolina	0.859	0.950
North Carolina	13340	95	Rural North Carolina	0.821	0.927
North Dakota	00820	01	North Dakota	0.870	0.930
Ohio	16360	01	Akron, Ohio	0.941	0.985
Ohio	16360	02	Cincinatti, Ohio	0.952	0.978
Ohio	16360	03	Cleveland, Ohio	0.963	1.023
Ohio	16360	04	Columbus, Ohio	0.952	0.966
Ohio	16360	05	Dayton, Ohio	0.934	0.998
Ohio	16360	06	Northwest (Lima), Ohio	0.920	0.946
Ohio	16360	07	Mansafield, Ohio	0.908	0.943
Ohio	16360	08	Springfield, Ohio	0.938	1.008
Ohio	16360	09	E. Central (Steubenville), Ohio	0.914	0.948
Ohio	16360	10	Toledo (Lucas/Wood), Ohio	0.987	0.982
Ohio	16360	11	Youngstown, Ohio	0.935	0.975
Ohio	16360	12	W. Central (Lake Plains), Ohio	0.908	0.938
Ohio	16360	13	Marion & Surr. cntys., Ohio	0.913	0.941
Ohio	16360	14	Scioto Valley, Ohio	0.935	0.955
Ohio	16360	15	Southeast (Ohio Valley), Ohio	0.902	0.946
Oklahoma	01370	01	Oklahoma City, et al (cities), Oklahoma	0.907	0.938
Oklahoma	01370	02	Tulsa, et al (cities), Oklahoma	0.900	0.956
Oklahoma	01370	03	Sm. Cities (Southern), Oklahoma	0.823	0.934
Oklahoma	01370	04	Sm. Cities (Northern), Oklahoma	0.830	0.922
Oklahoma	01370	99	Rural Oklahoma	0.833	0.935
Oregon	01380	01	Portland, et al (cities), Oregon	1.023	0.986
Oregon	01380	02	Eugene, et al (cities), Oregon	1.002	0.937
Oregon	01380	03	Salem, et al (cities), Oregon	0.986	0.948
Oregon	01380	12	SW Oregon cities (city limits)	0.983	0.947
Oregon	01380	99	Rural Oregon	0.991	0.957
Pennsylvania	00865	01	Philly/Pitt. Med. Schs/Hosps.	1.070	1.028
Pennsylvania	00865	02	Lg. Pennsylvania Cities	1.045	1.015
Pennsylvania	00865	03	Small Pennsylvania Cities	0.942	0.967
Pennsylvania	00865	04	Rural Pennsylvania	0.934	0.952

Appendix C.—GEOGRAPHIC PRACTICE COST INDEXES—Continued

State	Carrier	Locality	Name	PE Index[1]	PW Index[2]
Rhode Island	00870	01	Rhode Island	0.966	1.017
South Carolina	00880	01	South Carolina	0.823	0.941
South Dakota	00820	02	South Dakota	0.836	0.901
Tennessee	05440	35	Tennessee	0.836	0.939
Texas	00900	02	Northeast Rural Texas	0.833	0.937
Texas	00900	03	Southeast Rural Texas	0.845	0.946
Texas	00900	04	Western Rural Texas	0.803	0.922
Texas	00900	06	Temple, Texas	0.840	0.938
Texas	00900	07	San Antonio, Texas	0.877	0.945
Texas	00900	08	Texarkana, Texas	0.837	0.907
Texas	00900	09	Brazoria, Texas	0.900	1.051
Texas	00900	10	Brownsville, Texas	0.842	0.961
Texas	00900	11	Dallas, Texas	0.914	0.992
Texas	00900	12	Denton, Texas	0.914	0.992
Texas	00900	13	Odessa, Texas	0.914	1.016
Texas	00900	14	El Paso, Texas	0.847	0.989
Texas	00900	15	Galveston, Texas	0.912	0.964
Texas	00900	16	Grayson, Texas	0.854	0.928
Texas	00900	17	Longview, Texas	0.878	0.935
Texas	00900	18	Houston, Texas	0.942	1.028
Texas	00900	19	McAllen, Texas	0.828	0.890
Texas	00900	20	Beaumont, Texas	0.900	0.995
Texas	00900	21	Lubbock, Texas	0.835	0.900
Texas	00900	22	Waco, Texas	0.826	0.961
Texas	00900	23	Midland, Texas	0.938	1.045
Texas	00900	24	Corpus Christi, Texas	0.891	0.953
Texas	00900	25	Orange, Texas	0.900	0.995
Texas	00900	26	Amarillo, Texas	0.852	0.944
Texas	00900	27	Tyler, Texas	0.879	0.969
Texas	00900	28	Fort Worth, Texas	0.883	0.946
Texas	00900	29	Abilene, Texas	0.833	0.941
Texas	00900	30	San Angelo, Texas	0.854	0.908
Texas	00900	31	Austin, Texas	0.911	0.937
Texas	00900	32	Victoria, Texas	0.916	0.953
Texas	00900	33	Laredo, Texas	0.813	0.935
Texas	00900	34	Wichita Falls, Texas	0.849	0.938
Utah	00910	09	Utah	0.926	0.985
Vermont	00780	50	Vermont	0.891	0.885
Virginia	10490	01	Richmond & Charlottesville	0.893	0.950
Virginia	10490	02	Tidewater & N. Va. Counties	0.959	0.977
Virginia	10490	03	Sm. Town/Industrial Virginia	0.849	0.941
Virginia	10490	04	Rural Virginia	0.843	0.933
Washington	00930	01	W & SE Washington (excl. Seattle)	1.001	1.016
Washington	00930	02	Seattle (King Cnty), Washington	1.051	1.038
Washington	00930	03	Spokane & Richland (Cities), Washington	1.006	0.993
Washington	00930	04	E. Cen & NE Washington (Excl Spokane)	0.989	0.981
West Virginia	16510	16	Charleston, West Virginia	0.929	0.974
West Virginia	16510	17	Wheeling, West Virginia	0.880	0.949
West Virginia	16510	18	Eastern Valley, West Virginia	0.861	0.923
West Virginia	16510	19	Ohio River Valley, West Virginia	0.858	0.925
West Virginia	16510	20	Southern Valley, West Virginia	0.853	0.919
Wisconsin	00951	04	Milwaukee, Wisconsin	0.964	1.015
Wisconsin	00951	12	Northwest Wisconsin	0.868	0.939
Wisconsin	00951	13	Central Wisconsin	0.857	0.921
Wisconsin	00951	14	Southwest Wisconsin	0.857	0.921
Wisconsin	00951	15	Madison, Wisconsin (Dane County)	0.937	0.955
Wisconsin	00951	19	La Crosse, Wisconsin (W-Central)	0.889	0.948
Wisconsin	00951	36	Wausau, Wisconsin (N-Central)	0.866	0.941
Wisconsin	00951	40	Green Bay, Wisconsin (northeast)	0.879	0.958
Wisconsin	00951	46	Milwaukee Suburbs, Wisconsin (SE)	0.962	1.019
Wisconsin	00951	54	Janesville, Wisconsin (S-Central)	0.872	0.940

Appendix C.—GEOGRAPHIC PRACTICE COST INDEXES—Continued

State	Carrier	Locality	Name	PE_Index[1]	PW_Index[2]
Wisconsin	00951	60	Oshkosh, Wisconsin (E-Central)	0.878	0.948
Wyoming	05530	21	Wyoming	0.902	0.975

[1] PE_Index = Practice Expense Component Index.
[2] PW_Index = Physician Work Component Index.

DISSENTING VIEWS ON THE RELATIVE VALUE SCALE SYSTEM TO THE BUDGET RECONCILIATION LEGISLATION FOR FISCAL YEAR 1990 (TITLE IV, SUBTITLE A)

We are compelled to register our strong opposition to the Medicare fee schedule based on the Resource Based Relative Value Scale system [RBRVS], reported by the Committee on Energy and Commerce on July 13, 1989 as part of the budget reconciliation legislation for fiscal year 1990. While we agree that changes are needed within the current reasonable charge methodology for paying physicians, we are of the opinion that we need to evaluate the serious repercussions the RBVRS fee schedule may create for certain doctors and patients.

It is our belief that there may be a rush to implement the proposed fee schedule without examining the effects it may have on the health care delivery system. The recommendations of the Physician Payment Review Commission emphasizes the continuing need for additional studies and refinements on the RBVRS fee schedule. In fact, the Commission's report specifically states that there are several areas where the methodology must be improved. According to the report, even data used to study specialties must be reanalyzed and, in some cases, individual specialties must be restudied with the improved methodology.

For this reason, we must argue for a delay in adopting the new fee schedule so that methodologies for determining Medicare reimbursement to physicians for a particular service can be evaluated appropriately. It appears that 8 of the 18 medical specialties reviewed in the Hsiao study may be reanalyzed.

In addition, we are particularly concerned about the effects the RBVRS fee schedule will have on patients and physicians from specific geographic regions of the country such as Florida, California, and Texas. According to the Health Care Financing Administration, this proposal will create reductions in Medicare reimbursement of well over 30 percent for some physicians in these States. These reductions, in our view, could drastically affect services to both Medicare and non-Medicare patients. It is possible that all patients would bear the burden of the reductions in several ways, including less incentives for physicians to accept Medicare patients and higher medical bills for non-Medicare patients.

Finally, Congress must decide if the RBVRS fee schedule would actually lead to improvements in the Medicare program. It is our fear that a new fee schedule is just as likely to create difficulties in the Medicare reimbursement process as the current system. It is important to realize that a new reimbursement system will have inconsistencies and inadequacies that will need to be resolved. Therefore, we must proceed with great caution when implementing a new Medicare reimbursement fee schedule so the adverse impacts of this proposal will be minimized.

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DISSENTING VIEWS OF MEDICAID BUDGET RECONCILIATION AMENDMENTS (TITLE IV, SUBTITLE C)

We are compelled to register our strong opposition to the Medicaid Budget Reconciliation Amendments of 1989, reported by the Committee on Energy and Commerce on July 13, 1989. The five Medicaid provisions will greatly increase Federal spending in the Medicaid program, and accomplishes this by means of a Reconciliation bill which is supposed to be a budget-cutting vehicle. Under the Concurrent Resolution on the Budget for fiscal year 1990 (H. Con. Res. 106), $200 million of new budget entitlement authority [NEA] is available for fiscal year 1990 Medicaid spending. And, by slipping effective dates on some of the pending provisions so that only one calendar quarter's worth of spending occurs in fiscal year 1990, the provisions will technically meet the budget target. But in the outyears, these Medicaid provisions will cost additional billions of dollars. The Administration estimates that, taken together, these Medicaid measures will increase Federal spending in the Medicaid program by approximately $8.6 billion over a 5-year period.

We also think this legislation must be considered in the context of the Gramm-Rudman-Hollings Law. The Administration is the official scorekeeper, and to the extent that the legislation matches the Health Care Financing Administration [HCFA] estimates, the fiscal year 1991 budget deficit will be increased by $1.2 billion. This is at a time when the Gramm-Rudman-Hollings deficit target is set at $64 billion.

Irrespective of the various merits of these Medicaid provisions, the spending levels that these measures will produce violate any sense of restraint on increases in the Federal budget. And we must also not forget the Medicaid expansions that Congress has already enacted in the last few years as part of the Medicare Catastrophic Coverage Act, The Family Support Act, OBRA–87, and the Tax Technicals of 1988 which will have a major impact on Federal spending in fiscal year 1990. In fiscal year 1990 alone these four laws will increase Federal Medicaid expenditures by over $1 billion and the 5-year costs will exceed $11 billion.

Another major concern we have in the attempt to rationally analyze these Medicaid provisions is the vast difference between the cost estimates of these measures by the Congressional Budget Office [CBO] and the Health Care Financing Administration [HCFA]. The Congressional Budget Office estimates the Federal costs of these Medicaid provisions at approximately $4.1 billion over 5 years. Preliminary estimates from HCFA are 5-year costs of $8.6 billion. The fact that these estimates by CBO and HCFA *differ by $4.5 billion over a 5-year period* makes it extremely difficult to evaluate the true fiscal impact of these provisions. Though forecasting is not an exact science, a difference of this magnitude is truly disturbing.

In the recent past when we were considering the drug benefit under the Catastrophic Coverage Act in the Medicare program, there was a similar dispute between HCFA and CBO about the projected costs of a benefit. When the Catastrophic legislation was being considered, HCFA actuaries estimated that the cost of the drug benefit would be two to three times the cost estimated by

CBO. Now, CBO has reexamined its estimates on the basis of the latest available data and has concluded that the HCFA projections were essentially accurate. CBO has now substantially raised its estimates of outlays for both benefits and administrative costs to a total of $11.8 billion for the 1990–93 period. This figure of $11.8 billion is more than twice CBO's estimate of $5.7 billion of one year ago.

We must also be aware that the Federal costs of these Medicaid provisions, while great, are only half of the story. The States face equally large expenditures if these measures are enacted. There is also a fundamental equity issue among the States that arises in the Medicaid program with respect to these provisions. The more prosperous States are able to adopt Medicaid optional services because they have richer State treasuries. Because these States already offer a generous package of social services, expanding Medicaid options often allow these States to refinance such services. In terms of their programs and treasuries, these Medicaid options would make the rich States even richer. On the other hand, the Medicaid mandates tend to affect States experiencing tight budgets due to economic downturns. Richer States have already adopted these measures when they were first made optional in the past. Thus, these mandates have no effect on the richer States but cause others increased difficulty. The poorer States will be forced to choose among competing priorities when they finance these new mandates. The point is that these continuing cycles of options which later become mandates only serve to make the rich States richer and the poor States poorer.

A final concern is the provision in the legislation that directs the Physician Payment Review Commission to review Medicaid rates for physician services. This is an unnecessary intrusion of Federal oversight into an area that has been within the States' purview for many years. This would entail a dramatic expansion of the Physician Payment Review Commission's power and resources. The effect of this expansion of power would literally make the Commission a "junior" Health Care Financing Administration in the area of Medicaid policy.

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ADDITIONAL DISSENTING VIEWS ON THE HEALTH BUDGET RECONCILIATION AMENDMENTS (TITLE IV, SUBTITLE D)

I concur entirely with the dissenting views regarding the Medicaid provisions of the budget reconciliation package. These expansions are proving to be a tyranny over the States and are certainly unjustifiable in light of the fiscal year 1990 budget resolution and ongoing budget constraints. Beyond the immediate fiscal impact, however, there are long-term losses for many of the individuals Medicaid is intended to serve, particularly women and children.

It is clear from the hearings held in the Subcommittee on Health and other committees, as well as the National Commission to Prevent Infant Mortality, that poor health outcomes for infants and children result from many circumstances. Most of them are not cured by the provisions contained in these amendments. Rather, the amendments continue and expand a system that has already failed many women and children.

If we are truly committed to improving maternal and child health, we must reevaluate our methods of providing services. Above all, we must have the courage to loosen the bureaucratic reins, thereby demonstrating confidence in each State's concern for the well-being of its citizens and its ability to meet their needs in the most efficient and responsible manner.

During committee consideration of the health-related provisions of the budget reconciliation package, I offered an amendment which would have consolidated all pregnancy-related services to women and preventive services to children, including nutrition, so that they could be offered in integrated settings. While the amendment was not adopted during the committee meeting, I hope that, at the very least, it marked the start of a new look at health care for low-income families in our country.

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